Supreme Court, U.S.
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In The

Supreme Court of the United States

October Term, 1995

NATHAN AND SHARYL MCDONALD, INDIVIDUALLY AND AS NEXT FRIEND AND GUARDIANS OF NATHAN NEIL MCDONALD, A MINOR, AND J.N. MCDONALD JR., INDIVIDUALLY AND D/B/A MCDONALD EQUIPMENT,

Petitioners,

versus

PROVIDENT INDEMNITY LIFE INSURANCE COMPANY, ET AL.,

Respondents.

Petition For Writ Of Certiorari To The United States Court Of Appeals For The Fifth Circuit

PETITION FOR WRIT OF CERTIORARI

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QUESTIONS PRESENTED

1. Certiorari should be granted so that the Supreme Court may consider the split of authority now existing among the circuit courts of appeal on ERISA preemption of state law claims made by victims fraudulently induced to purchase ERISA plans and insurance policies later held to be ERISA plans. The purpose of ERISA preemption is to provide for the orderly (and legal) regulation of plan administration. Preemption was not meant to provide protection for fiduciaries who are also insurance agents and brokers who make money by defrauding purchasers of insurance. The circuit courts of appeal have recently rendered decisions which create a split of authority on this issue which should be addressed and clarified by the Supreme Court.

   The Supreme Court should make it clear that ERISA does not preempt state law claims of fraud in the inducement, deceptive trade practices and fraud employed by insurance agents and brokers to induce the purchase of insurance and/or ERISA plans. Specifically, the Supreme Court should make it clear that fiduciaries cannot use ERISA preemption as a shield for their fraudulent, deceptive and criminal practices in the selling of ERISA insurance products and services.

2. Is a conspiracy by the insurance company and the insurance agent who are also ERISA fiduciaries to raise health insurance rates to exorbitant levels **($2,000.00 - $15,000.00 per month)** to force victims to drop their coverage preempted by ERISA?

3. The Fifth Circuit erred (in a split of authority with the Eleventh Circuit) when it held a sole proprietorship, J.N. McDonald d/b/a McDonald Equipment Company, and the McDonalds, individually, could not

QUESTIONS PRESENTED – Continued

collect damages for fraudulent inducement to retain certain insurance coverage, when the McDonalds' damages included a calculation for loss of benefits.

4. If an ERISA plan was formed by the McDonalds, the McDonalds had to be administrators and fiduciaries. The Fifth Circuit opinion erred and holds the Business Insurance Trust (an entrepreneurial venture) is the plan and the McDonalds are the plan. Two separate entities cannot comprise the McDonalds' plan. Arden French and Provident Indemnity Life Insurance Company could not be ERISA fiduciaries because French and Provident Indemnity Life Insurance Company were strictly entrepreneurs who had never met or contracted with the McDonalds for anything other than the sale of insurance.

5. The Fifth Circuit erred when it held the bare purchase of insurance by a sole proprietorship formed an ERISA plan.

CERTIFICATE OF INTERESTED PERSONS

The following parties have an interest in the outcome of this case:

(1) Nathan and Sharyl McDonald, Individually and as next Friend and Guardians of Nathan Neil McDonald, a minor and J.N. McDonald Jr., Individually and d/b/a McDonald Equipment

(2) David L. Sheller

(3) Provident Indemnity Life Insurance Company, Arden O. French, Jr., Trustee for The Business Insurance Trust and The Business Insurance Trust

(4) Gene Creely, Boswell & Hallmark

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PETITION FOR WRIT OF CERTIORARI

Petitioners, NATHAN AND SHARYL MCDONALD, INDIVIDUALLY AND AS NEXT FRIEND AND GUARDIANS OF NATHAN NEIL MCDONALD, A MINOR, AND J.N.McDONALD JR., INDIVIDUALLY AND D/B/A MCDONALD EQUIPMENT, pray that this Honorable Court issue a Writ of Certiorari to review the judgment of the United States Court of Appeals for the Fifth Circuit in their case.

CITATION TO OPINION BELOW

The opinion of the United States Court of Appeals for the Fifth Circuit can be found at *McDonald v. Provident Indem. Life Ins. Co.*, No. 93-7362 (5th Cir. Aug. 9, 1995), and is attached as Appendix A.

STATEMENT OF JURISDICTION

Petitioners invoke the jurisdiction of this Court pursuant to 28 U.S.C. § 1254 (1).

CONSTITUTIONAL AND STATUTORY PROVISIONS AT ISSUE

Does ERISA preempt the fraudulent actions of insurance sellers whose misrepresentations and fraud violate the Texas Deceptive Trade Practices Act and the Texas

Insurance Code and the mail fraud statute, which relevant sections are set out as follows:

V.T.C.A., Bus. & C. §§ 17.46, et seq.

V.A.T.S. Insurance Code, art. 21.21

18 U.S.C. § 1001

Is self-dealing by alleged ERISA fiduciaries who are actually insurance sellers, preempted by the arbitrary and capricious standard of review? The relevant sections are set out as follows:

29 U.S.C. § 1106

29 U.S.C. § 1104

Is a calculation of damages which includes a calculation for loss of benefits preempted by ERISA? The relevant section is set out as follows:

ERISA § 514(a)

STATEMENT OF THE CASE

PILIC	=	PROVIDENT INDEMNITY LIFE INSURANCE COMPANY
NCM	=	NORTH CAROLINA MUTUAL LIFE INSURANCE COMPANY
BIT	=	BUSINESS INSURANCE TRUST OF GEORGIA
IRM	=	INSURANCE RESOURCES MANAGEMENT
PAC	=	PROVIDENT AMERICAN CORPORATION
CX	=	COMPLAINANTS' EXHIBIT NO.

A. Course of Proceedings Below.

Complainants filed this case in the United States District Court for the Southern District of Texas, Galveston Division, on September 6, 1991. The trial court denied discovery on everything, except the issue of whether or not there was an ERISA plan, beginning December 15, 1992, through March 17, 1993. The court denied Complainants' request for further discovery and the case went to trial before the Court on April 5, 1993. The trial court also denied Complainants' motion for continuance to conduct further discovery and request for a jury trial. The Court made a finding based on the contested summary judgment motion that there was an ERISA plan and denied all relief as to the state and federal law violations of fraud, self-dealing and breach of contract by French, the BIT and PILIC.

On August 9, 1995, the Fifth Circuit summarily denied all relief. *McDonald v. Provident Indem. Life Ins. Co.*, No. 93-7362 (5th Cir. August 9, 1995).

B. Statement of Relevant Facts.

On or about September 15, 1989, Nathan Neil McDonald, a four-year old, sustained a near drowning injury which rendered him a spastic quadriplegic.

In 1986, through the BIT, McDonald Equipment Company, a sole proprietorship owned by J.N. McDonald, a Plaintiff in this case, purchased health insurance for himself and his employees from NCM. Employees handled the filing of their own claims. Mr. McDonald and his son, Nathan McDonald, had nothing to do with the payment of or administration of claims. NCM and the McDonalds'

contract provided for the use of eight class factors to set premiums. In 1988, NCM dropped out of the health insurance business.

French then began his plan to defraud McDonald. French intentionally chose PILIC, a non-rated company by AM Best as a replacement company. French sent out an assumption letter to the McDonalds which represented PILIC as an AM Best rated company (CX 57 and CX 61, App. 31 and App. 32). These statements were false. French improperly wore three hats as the insurance agent, third-party administrator, and trustee of the BIT, an entrepreneurial venture. The BIT was formed by French in 1978 to market insurance and allow French's company, IRM, to act as third-party administrator. French had control as the trustee and sole member of the benefit committee. French chose PILIC to maximize his own financial gain and signed a contract which allowed PILIC to rate individually.

French and his company were also the general sales agent for each carrier which insured the trust. When NCM decided to drop the health insurance coverage for the BIT, Mr. French signed a three year contract with PILIC that **allowed PILIC to rate individually which did not spread their risk and, therefore, was not insurance, and gave French's company, IRM, an exclusive three year contract for administration and general agent's duties. French also received 100,000 shares of stock in the holding company and a seat on the board of directors.** No documents show when the stock was received. At the time of trial French who still does business with PILIC, had sold the stock for approximately a $250,000.00 profit.

J.N. McDonald's health insurance premiums were raised from approximately $2,000.00 per month to $15,200.00 per month in an eighteen (18) month period after Nathan Neil McDonald, a four-year old child, became a spastic quadriplegic, on September 15, 1989. The McDonalds still had available coverage in the amount of $640,486.90 on the date they were forced to drop their insurance coverage on March 31, 1991.

Over a year before Nathan Neil McDonald's injury, on September 30, 1988, French obtained a copy of PILIC's rate schedule which Mr. French admitted would force a small company incurring a catastrophic illness to drop their coverage. **French admitted that he did not disclose the rate schedule because of marketing considerations.**

In 1988, immediately after the takeover of the BIT's insurance, PILIC implemented the rate schedule complained of after PILIC received a consulting actuaries report from Koppel & Company, which showed PILIC how to implement tier ratings to force groups with catastrophic injuries to a group member to drop coverage (CX 8, App. 28).

In November 1989, French received two percent (2%) of the gross premiums which approximated $400,000 per year for the assignment of the benefit committee, trusteeship and administration duties of the BIT to employees of PILIC.

REASONS THIS COURT SHOULD GRANT THE WRIT

There is a split of authority between the Third Circuit and the Fifth Circuit on the status and duties of a fiduciary. The Fifth Circuit held without explanation that an insurance agent and insurance company who violated federal and state laws had absolute discretion to do so under their ERISA hats because French and, later, PILIC, were trustees of the BIT. The Fifth Circuit holding gave French and PILIC absolute discretion even though as insurance agents they fraudulently induced the McDonalds and others to purchase an illegal insurance plan. French and PILIC planned and conspired to do this by raising premiums astronomically on anyone who had a large claim (CX 8). French and PILIC also changed the policy terms from an occurrence policy to a claims made policy without telling the McDonalds.

The case of *Moench v. Robertson*, 62 F.3d 553 (3rd Cir. 1995) holds at p. 560:

> As these definitions imply, "[f]iduciary status . . . is not an 'all or nothing concept. . . . [A] court must ask whether a person is a fiduciary with respect to the particular activity in question." *Maniace v. Commerce Bank of Kansas City, N.A.*, 40 F.2d 264, 267 (8th Cir. 1994) (first alteration added), *cert. denied*, ___ U.S. ___, 115 S.Ct. 1964, 131 L.Ed.2d 854 (1995).

French and PILIC were insurance agents, administrators, and trustees. Their first loyalty was to their profits.

The *Moench* case holds at p. 572:

> [T]his case graphically illustrates the risk of liability that ESOP fiduciaries bear when they act

> with dual loyalties without obtaining the impartial guidance of a disinterested outside advisor to the plan. Because the potential for disloyal self-dealing and the risk to the beneficiaries from undiversified investing are inherently great when insiders act for a closely held corporation's ESOP, courts should look closely at whether the fiduciaries investigated alternative actions and relief on outside advisors before implementing a challenged transaction.

Id. at 670-71.

And, if the fiduciary cannot show that he or she impartially investigated the options, courts should be willing to find an abuse of discretion.

French was president of the third-party administrator and signed a contract with PILIC allowing them to rate individually. French's company, IRM, the third-party administrator, was the general sales agent for PILIC and received a commission on all premiums. French admitted that he did not disclose the rate increases to policyholders *because of marketing considerations*. The case of *Drennan v. General Motors Corp.*, 977 F.2d 246 (6th Cir. 1992), *cert. denied*, 113 S.Ct. 2416 (1993), held at p. 251:

> A fiduciary 'has a duty not only to inform a beneficiary of new and relevant information as it arises, but also to advise him of circumstances that threaten interests relevant to the relationship.'

The case further holds at p. 251 that "misleading communications to plan participants 'regarding plan administration will support a claim for a breach of fiduciary duty.' "

French's failure to disclose the PILIC rate structure obviously falls in this category along with his failure to disclose that he was allowing PILIC to rate individually. All these actions were in violation of the definition and purpose of insurance.

French violated his fiduciary duties to the BIT by failing to replace the other two (2) members of the benefit committee, thereby removing all *accountability*. French violated the terms of the BIT agreement by failing to notify certificate holders of the significant change in the policy from an occurrence policy to a claims made policy within thirty days as provided by Section 5.03(b) of the BIT agreement.

Under questioning by Judge Gibson, French admitted PILIC's September 30, 1988 letter, the tier rate schedule, would single out and cause a small group like McDonalds to be forced to drop their insurance if they experienced a catastrophic injury by triggering a prohibitive increase.

French admitted in his deposition that the purpose of insurance is to insure against a large loss and spread the risk of loss over a group, yet he did not notify the McDonalds that PILIC insurance did not protect them against a large loss.

French's company, IRM, was compensated on a percentage of gross premium and received more and more money as premiums increased since IRM's marketing and administration fees were based on a percentage of gross premiums.

French violated the prohibitions against self dealing contained in the BIT agreement, Section 5.05 and 29

U.S.C. § 1106, the Common Law, and the *Restatement of Trusts (Second)* § 170 *et seq.* So did PILIC when their employees became the benefit committee, and failed to act as would be expected of a reasonable and prudent person under the same or similar circumstances. 29 U.S.C. § 1104.

PILIC moved the BIT from Georgia to Mississippi because tiering as instituted by PILIC was illegal in Georgia. The testimony of Robert Jaffe and Dr. Hershbarger was that PILIC's tier rating schedule did not spread the risk.

The McCarran Ferguson Act defines insurance as a spreading of the risk. *Union Labor Life Ins. Co. v. Pireno,* 458 U.S. 119 (1982). French and PILIC's conduct also constituted wire fraud and mail fraud under 18 U.S.C. § 1001, *et seq.* The case of *Merchant's Home Delivery Service, Inc. v. Hall & Co.,* 50 F.3d 1486 (9th Cir. 1995) shows the overcharging of premiums committed by PILIC and French could constitute RICO violations and the relationship between the insured and insurer is the core of the business of insurance which is regulated by the states according to the McCarran Ferguson Act.

The Fifth Circuit's opinion fails to address how PILIC's violation and French's violation of other state and federal laws can be preempted by ERISA.

In *Perkins v. Time Insurance Co.,* 898 F.2d 470, 473 (5th Cir. 1990), for example, the plaintiff sued an insurance agent claiming that the agent fraudulently induced him to surrender his previous medical insurance coverage and elect to participate in an ERISA-covered plan. The court held that the plaintiff's state law fraudulent inducement

claim against the insurance agent was not preempted because it did not "relate to" an ERISA-covered plan within the meaning of ERISA § 514(a). The court emphasized that the claim did not implicate the plan's administration of benefits or "affect the relations among the principal ERISA entities (the employer, the plan fiduciaries, the plan, and the beneficiaries)." *See also Hardy v. Fisher*, 1995 U.S. Dist. LEXIS 15334 (E.D. Tex. Sept. 6, 1995) (sponsor's claim alleging that insurance agent violated the Texas Deceptive Trade Practices Act not preempted by ERISA); *Barnett v. Wainman*, 830 F. Supp. 610, 613 (S.D. Fla. 1993) (participant's state law negligence and fraud claims against insurance agent not preempted by ERISA); *Martin v. Pate*, 749 F. Supp. 242 (S.D. Ala. 1990) (participant's state law fraudulent inducement claim against insurance agent not preempted by ERISA); *Ingram v. American Chambers Insurance Co.*, 643 So. 2d 575 (Ala. 1994) (participant's state law fraudulent inducement claim against insurance agent not preempted by ERISA).

That the appellants' state law claims in this case arise after the plan's formation does not mean that they are preempted by ERISA. The U.S. Supreme Court's decision in *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Insurance Co.*, 115 S.Ct. 1671 (1995) makes clear that any such "uncritical literalism" in construing the term "relate to" is completely inappropriate. *Travelers*, 115 S.Ct. 1677. *Travelers* instead requires courts to consider "the objectives of the ERISA statute as a guide to the scope of the state law that Congress understood would survive." *Id.* Preempting state law claims against insurance agents simply because they arise after a plan's formation would not serve ERISA's objectives.

As the Supreme Court explained in *Travelers*, the purpose of ERISA preemption is "to avoid a multiplicity of regulation in order to permit the nationally uniform administration of employee benefit plans." *Id.* at 1677-78. State tort and contract claims against non-fiduciaries who sell insurance products to plans do not expose plans to a multiplicity of regulation even where the claims arise after a plan's formation. Such state law claims do not mandate any particular employee benefit structure. They instead leave employers completely free to custom design their employee benefit plans. Nor do such state law claims interfere with plan administration. On the contrary, if anything would interfere with plan administration, it would be the preemption of such state law claims, because ERISA-covered plans would be deprived of any meaningful recourse against non-fiduciaries who misrepresent the products and services which they market to the plans. Because ERISA imposes no contractual obligation or duty of care on those who sell products and provide services to plans, such state law claims cannot provide alternative enforcement mechanisms to ERISA. *Travelers*, 115 S.Ct. at 1678.

The McDonalds' claims do not seek to impose any particular benefit structure on the plan itself, nor do they interfere with the plan's administration. Appellants are not asserting any claims against the plan or its fiduciaries. **The McDonalds claim that an insurance broker and insurance company misrepresented the true cost of a replacement policy that was used to fund the plan, not that the plan itself was improperly administered or should be required to pay certain benefits.** Although damages may be measured by the value of the health

benefits that would have been provided under the plan in the absence of the alleged misrepresentations, that by itself is not enough to warrant ERISA preemption. *See Forbus v. Sears Roebuck & Co.*, 30 F.3d 1402, 1406-07 (11th Cir. 1994) (plaintiffs' claim that their employer fraudulently induced them to resign their employment was not preempted by ERISA even though their damages might include a calculation of lost pension benefits).

The McDonalds' claims are not preempted by ERISA. This case should be reversed and remanded for a new trial.

The Fifth Circuit found that the McDonalds formed a plan and were allegedly ERISA fiduciaries of said plan. It found that French and PILIC were also ERISA fiduciaries of the McDonalds' plan, even though the McDonalds had no contract with French or PILIC as administrators and had no knowledge of the actual activities of French or PILIC. The BIT and IRM were completely separate entities from the McDonalds.

The McDonalds also had nothing to do with the administration or payment of claims. Nathan McDonald stated in his deposition, "The employee had the claim form. He would fill out his own claim. He would submit the claim on his own. We never had anything to do with submitting claim forms for any employee." (T. Vol. 3, No. 35, Ex. "A," depo. of Nathan McDonald, p. 22, lines 20-24).

J.N. McDonald testified the company had no policy relating to the retention of records or how long they were kept. *Id.* at p. 48, lines 17-20. Nathan McDonald said he was unable to locate any company records reflecting the

eligible employees. *Id.* at p. 61, lines 4-7. The McDonalds had nothing to do with the determination of the eligibility of employees for insurance. The McDonalds did not even always provide claims forms. Nathan McDonald testified that if no forms were available he would have the employee call the agent, Robert Jaffe. *Id.* (T. Ex. "A," depo. of Nathan McDonald, p. 20, lines 21 & 25, p. 21, lines 1-11).

The owner of the company, J.N. McDonald, said it was his understanding that he *bought an insurance policy with competitive rates. Id.*, (Depo. of J.N. McDonald, p. 11, lines 11-15). The McDonalds originally purchased insurance from NCM through the BIT. Mr. Parrish was the vice president of NCM. His deposition on written questions was attached to the Complainants' Response to Defendants' Motion for Summary Judgment and was admitted at the trial. Parrish testified he did not know the source of financing for the plan in answer number 6. He also said that the BIT was not an ERISA trust in answer number 10, and that NCM did not intend to fund an ERISA trust when it wrote insurance for the Defendant BIT in answer number 11. The answers also show French's company, IRM, was the third-party administrator. The objective behind the trust and PILIC was to make money. This was confirmed by the regional marketing director of PILIC, Richard Wehr, who admitted in deposition that PILIC expected to make a profit of approximately $1,000,000.00 per year from the BIT. (T. Vol. 3 No. 35 depo. of Richard Wehr, p. 60, lines 16-19).

The case of *Donovan v. Dillingham*, 688 F.2d 1367 (11th Cir. 1982) held that a multiple employer trust is not an employee welfare plan. The United States Supreme Court

described what action constitutes a plan in *Fort Halifax Packing Co., Inc. v. Coyne*, 482 U.S. 1 (1987). The Court distinguished the difference between a benefit and a plan. The Court said: "The words benefit and plan are used separately throughout ERISA. Nowhere in the statute are they treated as the equivalent of one another." Finally, the *Fort Halifax* case implicitly applies to **employers. [French and PILIC were not the McDonalds' employers]**. The Court in *Fort Halifax* held:

> These statements reflect recognition of the administrative realities of employee benefit plans. An employer that makes a commitment systematically to pay certain benefits undertakes a host of obligations, such as determining the eligibility of claimants, calculating benefit levels, making disbursements, monitoring the availability of funds for benefit payments, and keeping appropriate records in order to comply with applicable reporting requirements. The most efficient way to meet these responsibilities is to establish a uniform administrative scheme, which provides a set of standard procedures to guide processing of claims and disbursement of benefits.

Id. at 9.

One of the first major cases to deal with multiple employer trusts was *Taggart Corp. v. Life & Health Benefits Admin.*, 617 F.2d 1208 (5th Cir. 1980), *cert. denied*, 450 U.S. 1030 (1981). The Fifth Circuit decided that the multiple employer trust was not an employee benefit plan:

> SMET is a proprietary enterprise, established and operated by independent businessmen for their personal profit . . . SMET acts as a mere

> conduit for hundreds of unrelated customers. . . . Neither Taggart Corp. nor any other employer participates in SMET's day-to-day operation or administration. The venture was established and is "maintained by entrepreneurs for the purpose of marketing products or services to others. . . . [Such an enterprise is neither] established [n]or maintained by the appropriate parties to confer ERISA jurisdiction."

Id. (Citing H.R. Rep. No. 94-1785, 94th Cong., 2d Sess. 48 (1977).

The Court further said, "Considering the history, structure and purposes of ERISA, we cannot believe that the Act regulates bare bone purchases of health insurance where, as here, the purchasing employer neither directly nor indirectly owns, controls, administers or assumes responsibility for the policy or its benefits." *Id.* at 1211.

The case of *Gahn v. Allstate Life Ins. Co.*, 926 F.2d 1449, 1452 (5th Cir. 1991) held that a trust was not an employee welfare benefit plan. The case of *MDPhysicians & Assoc., Inc. v. State Board of Insurance*, 957 F.2d 178 (5th Cir. 1992), *cert. denied*, 113 S.Ct. 179 (1992), holds at p. 183, that "just because a plan exists, however, does not necessarily mean the plan is an ERISA plan."

> In reaction to the broad range of 'persons' claiming 'employer' status to gain the protection of ERISA's broad preemption against application of state regulations, Congress evidenced its intent shortly after the passage of ERISA. The Activity Report of the Committee on Education and Labor revealed that certain entrepreneurs have undertaken to market insurance products

> to employers and employees at large, claiming these products to be ERISA covered plans. For instance, persons whose primary interest is in profiting from the provision of administrative services are establishing insurance companies and related enterprises. The entrepreneur will then argue that [its] enterprise is an ERISA benefit plan which is protected, under ERISA's preemption provision, from state regulation. . . . [W]e are of the opinion that these programs are not 'employee benefit plans'. . . . [T]hese plans are established and maintained by entrepreneurs for the purpose of marketing insurance products or services to others. They are not established or maintained by the appropriate parties to confer ERISA jurisdiction. . . . They are no more ERISA plans than is any other insurance policy sold to an employee benefit plan. . . . [W]e do not believe that the statute and legislative history will support the inclusion of what amounts to commercial products within the umbrella of the ['employee benefit plan'] definition. . . . [T]o be properly characterized as an ERISA employee benefit plan, a plan must satisfy the definition requirement of section 3(3) [, which defines 'employee benefit plan'], in both form and substance. H.R. Rep. No. 1785, 94th Cong., 2d Sess. 48 (1977). 'While not contemporaneous legislative history,' we, like other courts, find the Report 'virtually conclusive' as to legislative intent.

Id. at 184.

The court concluded its opinion by citing *Taggart* and disallowing entrepreneurial ventures ERISA plan status.

The *Gahn* case provides that the creation of an ERISA plan is a fact issue. Plaintiffs correctly created a fact issue which was improperly overruled by the Court. The Defendants' summary judgment did not meet the standard set forth in *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242 (1986) for a summary judgment. Further, the evidence submitted by Appellants as the non-movant is to be believed and all justifiable inferences are to be drawn in Appellants' favor. *Adickes v. S.H. Kress & Co.*, 398 U.S. 144 (1970). See, also, the McDonalds' Supplemental Response to Defendants' Motion for Summary Judgment. (T. Vol. 3, No. 36). The McDonalds did not establish an ERISA plan and the Appellees did not meet the burden of proof for summary judgment.

Therefore, this cause should be reversed and remanded for a new trial, upon ruling by the Supreme Court that the McDonalds did not have an ERISA plan.

Entrepreneurial ventures are not protected as employee welfare benefit plans under ERISA. The activity report of the Committee on Education and Labor of the United States House of Representatives No. 91,1785, dated January 3, 1977, n.4 contains the following pertinent language. While not contemporaneous legislative history, n.5 it is "virtually conclusive" as to legislative intent. *Sioux Tribe v. United States*, 316 U.S. 317, 329, 86 L.Ed. 1501, 62 S.Ct. 1095 (1942):

> "It has come to our attention, through the good offices of the National Association of State Insurance Commissioners, that certain entrepreneurs have undertaken to market insurance products to employers and employees at large, claiming these products to be ERISA covered

plans. For instance, persons whose primary interest is in profiting from the provision of administrative services are establishing insurance companies and related enterprises. The entrepreneur will then argue that his enterprise is an ERISA benefit plan which is protected, under ERISA's preemption provision, from state regulation. We are concerned with this type of development, but on the basis of the facts provided us, we are of the opinion that these programs are not 'employee benefit plans' as defined in Section 3(3). As described to us, these plans are established and maintained by entrepreneurs for the purpose of marketing insurance products or services to others. They are not established or maintained by the appropriate parties to confer ERISA jurisdiction, nor is the purpose for their establishment or maintenance appropriate to meet the jurisdictional prerequisites of the Act. They are no more ERISA plans than is any other insurance policy sold to an employee benefit plan.

* * * *

We are mindful of the potentially harmful effects of an overly broad interpretation of the term 'employee benefit plan' when coupled with the policy of section 514. As we have already noted, we do not believe that the statute and legislative history will support the inclusion of what amounts to commercial products within the umbrella of the definition. Where a 'plan' is, in effect, an entrepreneurial venture, it is outside the policy of section 514 for reasons we have already stated. In short, to be properly characterized as an ERISA employee benefit plan, a plan must satisfy the definitional

> requirement of section 3(3) in both form and substance." (Emphasis added).

Hamberlin v. VIP Ins. Trust, 434 F.Supp. 1196 at p. 1198 (D.C. Ariz. 1977). The *Hamberlin* case is factually on point.

J.N. McDonald was the sole proprietor of McDonald Equipment Company. In the event a plan exists, J.N. McDonald must be the plan. J.N. McDonald's premiums were actually paid directly to the BIT which was a dry trust. (Tr. II, 127, 285). The BIT passed the money directly to PILIC. The McDonalds lost all the premium payments and the $640,486.90 of coverage left on their son, Neil, a spastic quadriplegic.

In *Forbus v. Sears Roebuck & Co.*, 30 F.3d 1402 (11th Cir. 1994), the Eleventh Circuit held that a fraudulent representation that induced the plaintiff to quit his job was not preempted by ERISA. *Forbus* shows that the misrepresentation involved the very existence of the Plaintiffs' jobs. Furthermore, it holds at p. 1406, the mere fact that the plaintiffs' damages may be affected by a calculation of pension benefits is not sufficient to warrant preemption. *Pislo v. Bethlehem Steel Corp.*, 884 F.2d 116, 120-21 (4th Cir. 1989). In the present case, in which ERISA applies only peripherally, if at all – defies common sense to allow ERISA to preempt a state law fraud claim.

CONCLUSION

For these reasons, the decision of the Fifth Circuit should be reversed. The case should be remanded for a new trial because the Fifth Circuit incorrectly and

mechanically applies an ERISA fiduciary standard in a blanket matter to non-fiduciary actions.

Respectfully submitted,

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Attorney for Appellants

Nathan and Sharyl McDONALD, Individually and as Next Friend and Guardians of Nathan Neil McDonald, a Minor, and J.N. McDonald, Jr., Individually and d/b/a McDonald Equipment, Plaintiffs-Appellants,

v.

PROVIDENT INDEMNITY LIFE INSURANCE COMPANY, et al., Defendants-Appellees.

No. 93-7362.

United States Court of Appeals,
Fifth Circuit.

Aug. 9, 1995.

Employer and beneficiaries of its group health insurance plan brought suit against multiple employer trust which obtained the insurance, and its trustee, asserting that defendants violated the Employee Retirement Income Security Act (ERISA) in connection with prohibitive increases in premiums which followed single catastrophic loss. The United States District Court for the Southern District of Texas, Hugh Gibson, J., rendered judgment in favor of defendants, and plaintiffs appealed. The Court of Appeals, Politz, Chief Judge, held that: (1) employer's subscription to multiple employer trust to obtain group health insurance for its employees and their dependents constituted an ERISA "plan"; (2) arbitrary and capricious standard of review rather than de novo standard applied in reviewing trustee's actions as fiduciary; and (3) plaintiffs failed to prove "loss to plan" element required to establish claim for breach of fiduciary duty under ERISA.

Affirmed.

Appeal from the United States District Court for the Southern District of Texas.

Before POLITZ, Chief Judge, EMILIO M. GARZA and STEWART, Circuit Judges.

POLITZ, Chief Judge:

McDonald Equipment Company and employee-beneficiaries of its health insurance plan appeal an adverse summary judgment in their action complaining of excessive – and unaffordable – premium increases. We affirm.

Background

In 1986, McDonald Equipment, a sole proprietorship owned by J.N. McDonald, Jr., subscribed to the Business Insurance Trust to obtain group health insurance for its employees and their dependents. The BIT, a multiple employer trust, was organized by Arden O. French, Jr., who served as trustee and also owned Insurance Resources Management Corporation, the third party administrator of the group health plan. When McDonald subscribed in 1986, the BIT plan was underwritten by a policy issued by Northern Carolina Mutual. In 1988 North [sic] Carolina Mutual ceased providing health insurance and French selected Provident Indemnity Life Insurance Company as the replacement insurer. IRM continued as administrator until taken over by Provident in November 1989. French then resigned as trustee and the trusteeship was transferred first to three Provident employees and then to TrustMark Bank.

Nathan McDonald, the son of J.N. McDonald, Jr., managed the McDonald business. In September 1989, Nathan's son Neil suffered a tragic, near-fatal swimming

accident, resulting in a permanent spastic quadriplegic condition. Provident paid $360,000 in medical claims and raised McDonald Equipment's premium by 50 percent in April 1990 (McDonald changed its deductible from $100 to $500 to avoid a 150 percent increase), by 100 percent in November 1990, and by still another 100 percent in April 1991. As a result, McDonald's initial monthly premiums of $2000 were increased to $15,208. The company could not afford continued coverage and the policy lapsed.

The McDonalds and McDonald Equipment brought suit against Provident, the BIT and French, asserting various state law claims and alternatively invoking the Employee Retirement Income Security Act of 1974, 29 U.S.C. §§ 1001 et seq. Granting the defendants' motion for partial summary judgment, the district court found that McDonald's health coverage constituted an ERISA plan and preempted the state law claims. Following a bench trial on the remaining issues, the district court rendered judgment in favor of the defendants. This appeal timely followed.

Analysis

1. Was there an ERISA plan?

In reviewing the grant of summary judgment, we may affirm only if there is no dispute of material fact, and the movant is entitled to judgment as a matter of law.[1] The existence *vel non* of an ERISA plan is a question of fact.[2] Therefore, our initial inquiry focuses on whether

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[1] Fed.R.Civ.P. 56(c).

[2] *Gahn v. Allstate Life Ins. Co.*, 926 F.2d 1449 (5th Cir.1991).

the summary judgment evidence would have allowed a reasonable trier-of-fact to find that an ERISA plan did not exist.

ERISA defines an employee welfare benefit plan in pertinent part as:

> any plan, fund, or program which was . . . established or maintained by an employer or by an employee organization, or by both, to the extent that such plan, fund, or program was established or is maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise . . . medical, surgical, or hospital care or benefits. . . . [3]

Relying on *MD Physicians & Associates, Inc. v. State Board of Insurance*,[4] the McDonalds contend that the BIT was not such a plan. The BIT was established by French in association with an insurance company as an entrepreneurial venture, not by employers seeking to provide employee benefits and, further, it had no relationship with the employee-participants apart from the provision of benefits.[5] The BIT's status, however, is not dispositive. In determining whether an ERISA plan exists, we must focus on the employer and its involvement with the plan.

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[3] 20 U.S.C. Sec. 1002(1).

[4] 957 F.2d 178 (5th Cir.), *cert. denied*, ___ U.S. ___, 113 S.Ct. 179, 121 L.Ed.2d 125 (1992).

[5] *Id.*; *see also Donovan v. Dillingham*, 688 F.2d 1367 (11th Cir.1982) (en banc).

The dispositive issue is whether McDonald Equipment's *subscription* to the BIT constituted an ERISA plan.[6]

That inquiry is tripartite. First we apply the safe-harbor provisions established by Department of Labor regulations to determine whether the program was exempt from ERISA. Because McDonald Equipment paid the insurance premiums, it was not.[7] Next we look to see if there was a "plan" by inquiring whether "from the surrounding circumstances a reasonable person [could] ascertain the intended benefits, a class of beneficiaries, the source of financing, and procedures for receiving benefits."[8] Under this standard a plan clearly existed. The benefits provided by the McDonald plan were described in the Provident policy; the beneficiaries were the McDonald employees and their dependents; McDonald Equipment paid the entire premiums for coverage of its employees and a portion of the premiums for coverage of the dependents; and the procedures for recovering benefits were explained in the policy manual. Finally, we ask whether the employer "established or maintained" the plan for the purpose of providing benefits to its employees. McDonald Equipment did so, purchasing the insurance, selecting the benefits, identifying the employee-participants, and distributing enrollment and

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[6] *Gahn; Meredith v. Time Ins. Co.*, 980 F.2d 352 (5th Cir.1993); *Memorial Hospital System v. Northbrook Life Ins. Co.*, 904 F.2d 236 (5th Cir.1990). Unlike the case at bar, the status of the multiple employer trust was dispositive in *MDPhysicians* because the issue was whether the state could regulate the MET.

[7] 29 C.F.R. § 2510.3-1(j).

[8] *Memorial Hospital*, 904 F.2d at 240 (quoting *Dillingham*, 688 F.2d at 1373).

claim forms.[9] A reasonable fact-finder could have reached but one conclusion: McDonald's subscription to the BIT constituted an ERISA plan.

2. Standard of Review.

The McDonalds first contend that the district court erred in applying the arbitrary and capricious standard of review rather than a de novo standard in reviewing French's actions as a fiduciary. In *Firestone Tire & Rubber Company v. Bruch*,[10] the Supreme Court recognized that when a fiduciary is granted discretion in the performance of a duty the review is for an abuse of discretion. In the instant action the trust agreement creating the BIT gave French the absolute discretion to contract with an insurance provider. French acted under this authority in selecting PILIC and the district court correctly reviewed the decision under the arbitrary and capricious standard which is the equivalent of the abuse of discretion standard in this circuit.[11]

3. Did French breach his fiduciary duties in selecting PILIC?

At the outset, we note that as trustee of the BIT and principal of IRM, the third-party administrator, French

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[9] *Cf. Memorial Hospital.*

[10] 489 U.S. 101, 109 S.Ct. 948, 103 L.Ed.2d 80 (1989).

[11] *Penn v. Howe-Baker Engineers, Inc.*, 898 F.2d 1096 (5th Cir.1990) (equating arbitrary and capricious standard with abuse of discretion standard in ERISA context).

was a fiduciary of the McDonald plan.[12] The plaintiffs contend that French breached his fiduciary duty by not disclosing Provident's schedule for the re-rating of premiums, by selecting PILIC to underwrite the BIT policy, and by benefitting personally from the increased level of premiums. We review these claims under a three step analysis. To establish a claimed breach of fiduciary duty, an ERISA plaintiff must prove a breach of a fiduciary duty and a prima facie case of loss to the plan.[13] "Once the plaintiff has satisfied these burdens, 'the burden of persuasion shifts to the fiduciary to prove that the loss was not caused by . . . the breach of duty.' "[14]

In ruling on the McDonalds' nondisclosure claim, the district court held that French breached his fiduciary duty by failing to disclose PILIC's re-rating schedule for its group health coverage premiums to McDonald Equipment. We perceive no error in this holding. Section 404(a) imposes on a fiduciary the duty of undivided loyalty to plan participants and beneficiaries, as well as a duty to exercise care, skill, prudence and diligence.[15] An obvious component of those responsibilities is the duty to disclose material information.

Shortly after the effective date of the plan, PILIC advised French of a new rate schedule which French later conceded would have resulted in prohibitive premiums

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[12] *Donovan v. Mercer*, 747 F.2d 304 (5th Cir.1984).

[13] *Roth v. Sawyer-Cleator Lumber Co.*, 16 F.3d 915, 917 (8th Cir.1994).

[14] *Id.* at 917.

[15] 29 U.S.C. § 1104.

for any small employer experiencing a single catastrophic claim. French, however, failed to inform either McDonald Equipment or its employee-beneficiaries of the schedule, at least in part due to marketing considerations. Considering the impact that this rate schedule would have had on McDonald Equipment or any other small employer, this information was material to PILIC's suitability as a replacement insurer and McDonald's decision to remain in the BIT. Accordingly, French had an obligation to disclose.

The nondisclosure claim falters, however, at the second step of our analysis, specifically, the plaintiffs failed to prove a loss *to the plan* as required by 29 U.S.C. § 1109(a).[16] In *Massachusetts Mut. Life Ins. Co. v. Russell*,[17] the Supreme Court interpreted the "loss to the plan" language in § 1109 to limit claims under this section to those which inure to the benefit of the plan as a whole rather than to individual beneficiaries. The court noted that this interpretation reflected ERISA's primary concern with the possible misuse or mismanagement of plan assets.[18]

A close examination of the McDonalds's claim does not disclose how it involved the requisite "loss to the plan" as described in Russell. The resulting harm of the breach of French's fiduciary duties was the payment of higher premiums which ultimately lead to the decision,

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[16] The plaintiffs assert that the defendants are liable under § 409 of ERISA, codified at 29 U.S.C. § 1109.

[17] 473 U.S. 134, 105 S.Ct. 3085, 87 L.Ed.2d 96 (1985).

[18] *Id.* at 140-42 & n. 8, 9, 105 S.Ct. at 3089-90 & n. 8, 9, 87 L.Ed.2d at 102-03 & n. 8, 9 (discussing legislative history).

albeit under economic duress, to discontinue insurance coverage with the BIT. The relief sought is the balance of the benefits due for the treatment of Neil McDonald. This relief, unfortunately in this legal analysis, inures to the benefit of the McDonalds, not the plan, and thus has no impact on plan assets. Were we to consider the prohibitive increases in premiums as the injury or loss, these increases actually made the plan itself healthier and more likely to survive the catastrophic claims of other beneficiaries, including other McDonald Equipment employees.[19] We must therefore conclude that the McDonalds failed to establish a loss to the plan.[20] Further, because the showing of a loss to the plan is required for any breach of fiduciary duty claim under § 1109, the McDonalds' other breach claims also fail.

4. Other claims.

The remaining claims have no merit. The state law civil conspiracy and fraud claims are preempted by ERISA.[21] The district court did not err in denying a jury trial on the ERISA claims.[22] Finally, we find no abuse of

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[19] The plaintiffs also failed to provide any evidence that coverage was available from other companies under better terms.

[20] *See Total Plan Services v. Texas Retailers Assoc.*, 932 F.2d 357 (5th Cir.1991) (dismissing claim for failure to allege a loss to the plan); *Physicians HealthChoice, Inc. v. Trustees of Automotive Employee Benefit Trust*, 988 F.2d 53 (8th Cir.1993).

[21] *See Christopher v. Mobil Oil Corp.*, 950 F.2d 1209 (5th Cir.), *cert. denied*, ___ U.S. ___, 113 S.Ct. 68, 121 L.Ed.2d 35 (1992).

[22] *Borst v. Chevron Corp.*, 36 F.3d 1308 (5th Cir.1994); *Calamia v. Spivey*, 632 F.2d 1235 (5th Cir.1980).

discretion in the district court's termination of discovery.[23]

AFFIRMED.

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[23] *See Wichita Falls Office Assoc. v. Banc One Corp.*, 978 F.2d 915 (5th Cir.1992), *cert. denied*, ___ U.S. ___, 113 S.Ct. 2340, 124 L.Ed.2d 251 (1993) (according great deference to judge's decision to curtail discovery).

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF TEXAS
GALVESTON DIVISION

NATHAN AND SHARYL MCDONALD, ET AL.	§	
Plaintiff	§	CIVIL ACTION NO. G-91-321
vs.	§	
PROVIDENT INDEMNITY LIFE INSURANCE CO., ET AL.	§	(Filed May 12, 1993)
Defendant.	§	

FINDINGS OF FACT
AND CONCLUSIONS OF LAW

COMES NOW, the Court and presents its FINDINGS OF FACT AND CONCLUSIONS OF LAW with respect to liability and damages in Plaintiffs McDonalds' cause of action against Defendants Provident Life Insurance Company, the Business Insurance Trust, and Arden O. French, as the trustee of the Business Insurance Trust. The parties tried their case before the Court April 5 through 7, 1993 upon claims brought under the Employee Retirement Income Security Act of 1974 (ERISA). The Court found in favor of Defendants in its FINDINGS OF FACT AND CONCLUSIONS OF LAW pursuant to Fed.R.Civ.P. 52.

I. Background

In 1986, McDonald Equipment Company subscribed to a group health plan for its employees through the Business Insurance Trust. At the time of the subscription,

the subject group health plan was underwritten by a group health policy issued by North Carolina Mutual Insurance Company (North Carolina Mutual). Later, McDonald Equipment's health plan was replaced by Provident Indemnity Life Insurance Company (Provident).

On September 15, 1989, Nathan Neil McDonald, son of Plaintiffs Nathan and Sharyl McDonald, nearly drowned and became a spastic quadriplegic as a result of the accident. After the accident, Plaintiffs' premiums rose 50% in February 1990, 100% in August 1990, and in February 1991, another 100% increase occurred. Finally, in March 1991, the premium statement showed that premiums were raised to $15,208 per month.

Subsequently, McDonald Equipment's participation in the Provident group health plan ceased due to nonpayment of premiums, beginning with the March 1991 premium. In May 1991, Provident sent the McDonalds a letter stating that no bills after March 31, 1991 would be paid.

The Provident policy did contain a provision which extended benefits for any covered person, who fit the policy's description of "totally disabled," at the time of termination, for any covered medical expenses incurred during the three month period following termination of the policy. However, no claims were made under that provision.

Plaintiffs, Nathan and Sharyl McDonald and J.N. McDonald, individually, and D/B/A McDonald Equipment Company then brought suit against Provident Indemnity, The Business Insurance Trust and its Trustee

Arden O. French, Jr. asserting various state law claims and alternative claims under the Employee Retirement Income Security Act of 1974 (ERISA), 28 U.S.C. § 1001, et seq. (West 1985, & Supp. 1993).

On March 17, 1993, this Court entered an order holding that McDonald Equipment's group health plan was a qualified employee welfare benefit plan under ERISA, thus Plaintiffs' state law claims were preempted.

II. Findings of Fact

Based on the evidence presented in this case, the Court makes the following findings of fact:

1. The Business Insurance Trust (BIT) is a "dry trust" which was established in 1978 as a vehicle for allowing small businesses to obtain group health insurance. §§ 3.03, 3.04 of the Trust Agreement, Plaintiffs' Exhibit No. 4.

2. North Carolina Mutual underwrote the group health plan held by the Business Insurance Trust beginning in 1985.

3. Arden O. French, Jr. was the trustee of the Business Insurance Trust until November 13, 1989.

4. Prior to November 1989, Insurance Resources Management (IRM) had acted as third-party administrator for the collection of premiums and the handling of claims for the group health plan. Arden O. French, Jr. was the president of IRM.

5. McDonald Equipment Company, in 1986, began participating in the group health plan for its subscribing

employees and their dependents. North Carolina Mutual was still the underwriter of the health plan and IRM was the third-party administrator.

6. Plaintiff Nathan "Nate" McDonald as manager of McDonald Equipment Company signed the health plan agreement which contained an acknowledgment provision.[1] From the beginning of their participation with the Business Insurance Trust, Plaintiffs had knowledge that the premiums were variable and could be re-rated. *See* Defendants' Trial Exhibit No. 3.

7. In early May 1987, North Carolina Mutual notified French that it intended to stop underwriting group health coverage.

8. Mr. French at that time made inquiries for available replacement coverage for all participating employers, including McDonald Equipment Company. Trial Testimony of Arden O. French, Jr. At trial, Plaintiffs presented no evidence supporting a finding that other companies, better qualified than Provident, were ready and able to underwrite a substantially similar policy, for similar rates to that of North Carolina Mutual's policy.

9. After meeting with numerous representatives of various insurers, French selected Provident Indemnity Life Insurance Company because he believed that it would provide the best available group health plan to

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[1] "this is a variable re-[r]ated trust which allows cases to be rated on claims experience, history, census data, medical cost, area rating, industry classification and health conditions." (bold in original). Defendants' Trial Exhibit No. 3.

replace North Carolina Mutual's plan of coverage for all participating employers. Testimony of Mr. French.

10. The Provident policy became effective August 1, 1988. Provident sent a letter to certificate holders stating that the new policy was "substantially" similar to prior policy. *See* Trial Exhibit No. 57, Letter dated August 18, 1988. Prior, IRM had sent letter to McDonald Equipment in July 1988 notifying them of new coverage. Plaintiff Trial Exhibit No. 61.

11. No evidence was presented at trial to support a finding that Mr. French received any renumeration or consideration for the placing of the BIT group plan with Provident in summer 1988.

At trial, Mr. French acknowledged that he had resigned in November 1989 as trustee and assigned those duties to three individuals which were later assigned to TrustMark Bank. He received compensation in November 1989 for the transfer of IRM's administration of the BIT health plan to Provident. Provident paid an amount in cash, and 100,000 shares of stock in Provident American Corporation for this business. Later in January 1990, Mr. French acquired a position as a director at Provident American Corporation. *See* French Trial Testimony and Plaintiffs' Trial Exhibit No. 5, Trust Assignment and Assumption Agreement.

However, no evidence was presented that contradicted his testimony that his receipt of the cash, stock and later the position on the board of Provident American did not influence nor compensate him for his earlier decision to place the group health plan with Provident. *See* Trial

testimony and Deposition dated Nov. 1992 of Arden O. French, Jr.

Additionally, no evidence was presented that other, better insurers were available and ready to do business with BIT and Mr. French selected Provident solely for his own gain. *See* Testimony of Arden O. French, Jr.

Much argument and testimony at trial related to the A.M. Best ratings of insurance carriers. It is noted by the Court that the A.M. Best report of Provident was for the year 1987, in which Provident was rated NA-7, "below minimum standards." Plaintiffs' Trial Exhibit 69.

However, Provident had previously rated, "C" for 1983 and "C+" for 84, 85, 86, which is "fairly good." In 1987, the Best comments section portrayed Provident and its management favorably. Furthermore, the company appeared solid, innovative and sensitive to its clients' needs based on the A.M. Best report comments for that same year. The most telling point and significant proof as to worth, nevertheless, is that Provident did pay Plaintiffs' claims.

12. Evidence presented at trial and comparison of the two policies supports a finding of fact that the Provident policy was substantially similar in coverage to the coverage obtained under the North Carolina Mutual policy. Defendants' Exhibit 2 and 9. Testimony of Dr. Bob Hershbarger and Mr. Joseph Hawkins.

13. The premiums under the Provident policy were adjusted based on a participating employer's claim history according to a tier re-rating structure. Many insurers use this same system of determining premium rates,

although North Carolina Mutual did not use it from 1986-1988. Testimony of Joseph Hawkins and Plaintiffs' trial Exhibit No. 3.

14. Mr. French was not aware of specific information regarding the basis of re-rating premiums under the Provident policy, although he had general knowledge that Provident used a tier system. Plaintiffs' Exhibit 57, letter dated 9/30/88.

15. In November 1989, Mr. Arden French, Jr. ceased to be the trustee of BIT. The duties of the trustee were assigned, for a short period, to three individuals and eventually the duties were assigned to TrustMark Bank, Jackson, Mississippi. *See* Plaintiffs' Trial Exhibit No. 5.

16. In November 1989, Provident acquired the third-party administrator business of IRM. At that time, or soon after, Mr. French received compensation in cash and stock for the transfer. Testimony of Arden O. French, Jr.

17. The Business Insurance Trust was transferred from Georgia to Mississippi. However, no evidence was presented that the transfers and acquisition affected any change in the group health coverage nor the handling of the claims.

18. In February or March 1991, McDonald Equipment allowed its group health coverage to lapse when it discontinued paying premiums due to the great increase in the premiums. The group health coverage terminated effective March 31, 1991. *See* Defendants' Trial Exhibit No. 28.

19. Plaintiffs did not have any unpaid claims remaining under the Provident policy for medical

expenses incurred by them through the termination date. Trial Testimony of Charlene Scott, Claims Supervisor of Provident Indemnity.

20. The Provident policy contained a three-month extension of benefits provision which provided for an extension of benefits for related covered medical expenses incurred during the three-month extension period for any covered person declared to be "totally disabled" at the time of termination of coverage. Defendants' Exhibit 9.

21. Although, two other definitions of "totally disabled" exist in the Provident policy, "totally disabled" at the time of termination is defined in the three-month extension of benefits provision as "confined as a bed patient in a hospital."[2]

24. Nathan Neil McDonald did not qualify under the three-month extension of benefits definition of "totally disabled." Furthermore, no evidence was presented that Plaintiffs submitted any claims after termination of their policy to Provident under this three-month extension of benefits provision.

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[2] p. 3-3 of Provident policy, defines "Total Disability" for Dependents, at "C." Lower on the same page, "Totally Disabled" is also defined as "having a Total Disability as defined above." On p. 6-1 of policy, Section 6, is the Extension of Certain Benefits Upon End of Insurance While Totally Disabled provision. In this provision "Totally Disabled" is defined for individuals other than employees as "confinement as a bed patient in a hospital." All three definitions are unambiguous and it is evident that the definition within Section 6 becomes operative at the time of termination of the policy.

II. Conclusions of Law

1. Jurisdiction is proper in this Court pursuant to the Employee Retirement and Income Security Act of 1974 (ERISA), 28 U.S.C. § 1001, et seq. (West 1985 & Supp. 1993).

2. Mr. Arden French, Jr. had a duty to seek replacement group health coverage after North Carolina Mutual notified him that it intended to cancel its group health coverage which underwrote McDonald Equipment's group health plan.

3. Mr. French did not act arbitrarily and capriciously in placing the replacement group health plan with Provident Indemnity. *See* 29 U.S.C. § 1104, and the Business Insurance Trust Agreement, Defendants Trial Exhibit No. 1. Trial testimony of Arden O. French, Jr. *See* also Sections 5.03, 5.20, 5.02 of the Trust Agreement, Plaintiffs' Exhibit No. 1, which allow absolute discretion to trustee in contracting with provider and in pursuing the interests of the trust.

4. Mr. French had a duty to disclose information and had knowledge (as of 9-30-88) regarding Provident's basis for pricing or re-rating of premiums for group health coverage in which McDonald Equipment was a participant. 28 U.S.C. § 1104, *See* Plaintiffs' Exhibit No. 44 relating to disclosure of rating practices and No. 16.

However, Plaintiffs have not proven by a preponderance of the evidence that his failure to disclose resulted in damages to them. Plaintiffs were aware that premiums could possibly increase, and the Provident premiums did increase even before Nathan Neil McDonald's

accident.[3] McDonald Equipment was also aware that premiums could increase when their plan was being underwritten by North Carolina Mutual. No evidence was presented that Plaintiffs complained during any of those other increases, or sought information on premium rating, or help in changing insurers prior to March 1991.

5. Plaintiffs have not proven by a preponderance of the evidence that Defendants breached any duty by transferring the duties of trustee from French to the three employees of Montgomery Management Corporation, a subsidiary of Provident in November 1989, and ultimately to TrustMark Bank.

6. Defendants have proven by clear and convincing evidence that Mr. French did not breach any duty by assigning the administrative responsibilities from insurance Resources Management to Provident in November 1989 and receiving compensation for the assignment/transfer.

A manager for an ERISA plan must unequivocally cease to serve in position of professional advisor and terminate in writing all contracts or arrangements before playing any role in transactions denied to fiduciaries by ERISA's conflict of interest section 1106. *Lowen v. Tower Asset Management, Inc.*, 829 F.2d 1209 (2nd Cir. 1987).

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[3] *See* Plaintiffs' Exhibit No. 21. The premiums prior to Nathan Neil McDonald's accident were increased 100% on 11/1/88, 18% at 4/89. Each increase prior to and after the accident were noticed to Plaintiffs' at least 30-days before it went into effect. Plaintiffs' Trial Exhibits 14, 17, 58, 65. Exhibit 62 indicates in letter form that the premium increase as of 10/1/88 was for 25%.

Section 1106 gives notice to fiduciaries that they must either avoid the transaction or cease serving in their capacity as fiduciaries. *Id.* at 1213. Defendants have the burden of proof on this issue based on clear and convincing evidence. *Id.* at 1215.

Defendants have met this burden. Mr. French resigned his position and was no longer the trustee when he received the stock and cash in return for transferring the administrative business of IRM to Provident in November 1989. Mr. French did not assume his position as director of Provident American Corporation until 1990. Both events were more than a year past Mr. French's placing the BIT contract with Provident, which was in July 1988. *See* Trial Testimony of Arden O. French, Jr. and Plaintiffs' Trial Exhibit No. 5, Trustee Assignment and Assumption Agreement.

7. Defendants breached no duty by transferring the Business Insurance Trust from Georgia to Mississippi in November 1989.

8. Plaintiffs have not proven damages which occurred as a result of the transfer of duties of the trusteeship from Mr. French to the three individuals and ultimately TrustMark Bank.

9. No harm occurred to Plaintiffs which was caused by the transfer of administrative responsibilities for the subject group health plan from Insurance Resources Management to in-house at Provident in November 1989.

10. No harm occurred to Plaintiffs by the transfer of the Business Insurance Trust from Georgia to Mississippi in November 1989.

11. If any of the foregoing findings of fact constitute conclusions of law, they are adopted as such. If any of the foregoing conclusions of law constitute findings of fact, they are adopted as such.

CONCLUSION

Accordingly, the Court FINDS that Defendants Provident Indemnity Life Insurance Company, Arden O. French, Jr., as Trustee of the Business Insurance Trust, and the Business Insurance Trust, are not liable to Plaintiffs, Nathan and Sharyl McDonald, individually and as next friend and guardians of Nathan Neil McDonald, a minor, and J.N. McDonald, individually and D/B/A McDonald Equipment for injury pursuant to 28 U.S.C. § 1001, et seq. Therefore, it is

ORDERED and ADJUDGED that Defendants are not liable to Plaintiffs for damages pursuant to the Employment Retirement Income Security Act (ERISA) 28 U.S.C. §§ 1001, et seq.[4] for breach of any duty.

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[4] Specifically, §§ 1104, 1106, 1109 and 1132.

DONE at Galveston, Texas, this the 10th day of May, 1993.

/s/ Hugh Gibson
UNITED STATES DISTRICT JUDGE

/mb

IN THE UNITED STATES COURT OF APPEALS
FOR THE FIFTH CIRCUIT

No. 93-7362

NATHAN and SHARYL MCDONALD, Individually and as Next Friend and Guardians of Nathan Neil McDonald, A Minor and J. N. MCDONALD, JR., Individually and d/b/a McDonald Equipment,

Plaintiffs-Appellants,

versus

PROVIDENT INDEMNITY LIFE INSURANCE COMPANY, ET AL.,

Defendants-Appellees.

Appeal from the United States District Court for the Southern District of Texas

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ON PETITION FOR REHEARING

(SEPTEMBER 15, 1995)

Before POLITZ, Chief Judge, EMILIO M. GARZA and STEWART, Circuit Judges.

PER CURIAM:

IT IS ORDERED that the petition for rehearing filed in the above case is denied.

ENTERED FOR THE COURT:

/s/ Henry A. Politz
United States Circuit Judge

CLERK'S NOTE:
SEE FRAP AND LOCAL RULES 41 FOR STAY OF THE MANDATE.

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF TEXAS
GALVESTON DIVISION

NATHAN AND SHARYL MCDONALD, INDIVIDUALLY AND AS NEXT FRIEND AND GUARDIANS OF NATHAN NEIL MCDONALD, A MINOR, AND J.N. MCDONALD JR., INDIVIDUALLY AND D/B/A MCDONALD EQUIPMENT Plaintiffs, vs. PROVIDENT INDEMNITY LIFE INSURANCE COMPANY, ET AL. Defendants.	§	CIVIL ACTION NO. G-91-321 (Filed Jun. 4, 1993)

FINAL JUDGMENT

In accordance with the Court's FINDINGS OF FACT AND CONCLUSIONS OF LAW entered May 12, 1993, it is

ORDERED, ADJUDGED and DECREED that Plaintiffs Nathan and Sharyl McDonald, individually and as next friend and guardians of Nathan Neil McDonald, a minor, and J.N. McDonald, individually and D/B/A McDonald Equipment TAKE NOTHING by way of this cause of action against Defendant Provident Indemnity Life Insurance Company, the Business Insurance Trust and Arden O. French as trustee of the Business Insurance Trust. In addition each party incuring [sic] costs shall bear the same.

This is a FINAL JUDGMENT.

DONE at Galveston, Texas, this the 3rd day of June, 1993.

/s/ Hugh Gibson
UNITED STATES DISTRICT JUDGE

App. 28

PLAINTIFF'S EXHIBIT

FORT WASHINGTON, PENNSYLVANIA

COST SAVINGS PLAN

LOSS RATIOS BY CURRENT RATE FACTOR

Our inspection of the loss ratios by current rate factor study indicates to us that the level of tiering has not been adequate to create consistent loss ratios between cases. Loss ratios for the most recent twelve months increase with the level of current factor. In a perfect tiering system, these loss ratios would be expected to be more level, although some increase is certain in that these are cases with recent bad experience. The attached exhibits, however, clearly show that policies with low current rate factors continue to have good experience, while those with high factors continue to result in losses.

We derive from this that Provident Indemnity is suffering in its experience from the effects of poor experience on its existing groups which aren't paying their equitable share of the required premium.

We therefore recommend that a steeper tiering method be used to apply to in force cases. Our approach has been to identify groups with enough experience, either through accumulated premium or duration, to be reasonably credible. We generally identify the top 20% to 25% of these cases and increase their rates by a level sufficient to knock most, if not all out. The level depends on overall loss ratios, and target loss ratios, but with the levels that Provident indemnity [sic] is currently running, and the current marketing rates, a rate increase level of 50% over current levels or marketing levels if greater seems appropriate. Those who wish to, may re-qualify through re-underwriting at current market rates, with the requirement that a new pre-existing conditions exclusion be established. This approach has several advantages.

Employers with employees who will continue to be on expensive claims are charged more appropriate premiums, although they are not cancelled. Therefore, Provident Indemnity doesn't have to offer conversion policies which would be necessary if coverage was cancelled.

In order to maintain the purity of the block, those employers with bad experience in the past must be assumed to continue to have high claims ratios. Tiering is the sole available method of either forcing such cases to seek alternative coverage or paying their fair and equitable share of the cost. As long as competitors are underwriting and sharply tiering their in force block, Provident Indemnity must follow suit in order to be profitable.

The method is objective. It does not require case by case analysis which results in dissatisfaction from producers if judgment is used. It is simple to explain to producers, and they to their clients. Furthermore, because it is commonly used in the industry, they understand it.

The method is easier to administer. Groups that receive tiered rate increases can be assigned special codes which permit them to be analyzed separately as to experience.

PROVIDENT INDEMNITY
LIFE INSURANCE COMPANY

A Division of Provident American Corporation

Quality Insurance since 1889

August 18, 1988

Dear Certificateholder:

Effective August 1, 1988, Provident Indemnity Life Insurance Company has underwritten the benefit program previously written by North Carolina Mutual described as The American Liberty Series.

The new master policy benefits provided by the Provident Indemnity Life's plan are substantially the same as the benefits under the old plan. For instance, credit will be given under the new plan for deductibles and out-of-pocket expenses satisfied for the 1988 Calendar Year.

Please attach this letter to your old Benefit Booklet for future reference.

Sincerely,

/s/ Paul Pollock
Paul Pollock Vice President

PLAINTIFF'S EXHIBIT

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DEPOSITION EXHIBIT

N. McDonald 6
11/11/22

INSURANCE RESOURCES MANAGEMENT CORP.

P. O. BOX 4705
MONROE, LOUISIANA 71211-4705
318/387-8580

JULY 25, 1988

MCDONALD EQUIPMENT
RT. 4 BOX 270
BAY CITY, TX 77414

POLICY NUMBER: G100TX0734
GROUP EFFECTIVE DATE: 09-01-86
INSURANCE AGENT: WALTER SHEPHERD

DEAL POLICYHOLDER:

INSURANCE RESOURCES MANAGEMENT CORPORATION IS VERY PLEASED TO ANNOUNCE THAT EFFECTIVE AUGUST 1, 1988 YOUR GROUP AND HEALTH COVERAGE WILL BE ASSUMED BY PROVIDENT INDEMNITY LIFE INSURANCE COMPANY LOCATED IN NORRISTOWN PA. PROVIDENT INDEMNITY IS A RATED BEST CARRIER THAT HAS BEEN IN BUSINESS SINCE 1904. WE ARE EXTREMELY HAPPY TO HAVE THE OPPORTUNITY TO ASSOCIATE WITH SUCH A FINE ORGANIZATION AS PROVIDENT INDEMNITY AND WE LOOK FORWARD TO A LONG RELATIONSHIP IN THE YEARS AHEAD.

YOUR BENEFIT PACKAGE WITH PROVIDENT INDEMNITY IS IN KEEPING WITH YOUR PRESENT COVERAGE AND THERE WILL BE *NO* RATE CHANGE IN YOUR BILLINGS STATEMENT AS OF AUGUST 1, 1988. PLEASE NOTE THAT IF YOU HAVE AN OUTSTANDING BALANCE ON YOUR PREMIUM STATEMENT,

YOU MUST PAY THE FULL BALANCE DUE IN ORDER TO AVOID ANY LAPSE IN COVERAGE. AN ASSUMPTION CERTIFICATE AND NEW I.D. CARDS ARE BEING PREPARED AT THIS TIME FOR DISTRIBUTION TO YOU. ALL CLAIM AND SERVICE WORK WILL BE HANDLED OUT OF OUR MONROE, LOUISIANA OFFICE.

SHOULD YOU HAVE ANY QUESTIONS, PLEASE CONTACT THIS OFFICE OR YOUR AGENT.

SINCERELY

INSURANCE RESOURCES MANAGEMENT CORPORATION
GROUP ADMINISTRATOR

CC: WALTER SHEPHERD
2100 TRAVIS STE 703
HOUSTON, TX 77002

PLAINTIFF'S EXHIBIT

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DEPOSITION EXHIBIT

N. McDonald 21
11/11/22

(2)

Supreme Court, U.S.
FILED
FEB 15 1996
CLERK

No. 95-1166

In The

Supreme Court of the United States

October Term, 1995

NATHAN AND SHARYL MCDONALD, INDIVIDUALLY AND AS NEXT FRIENDS AND GUARDIANS OF NATHAN NEIL MCDONALD, A MINOR, AND J. N. MCDONALD, JR., INDIVIDUALLY AND D/B/A MCDONALD EQUIPMENT COMPANY,

Petitioners,

versus

PROVIDENT INDEMNITY LIFE INSURANCE COMPANY, ET AL.,

Respondents.

Petition For Writ Of Certiorari To The United States Court Of Appeals For The Fifth Circuit

BRIEF IN OPPOSITION

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Attorney of Record for Respondents
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QUESTIONS PRESENTED

1. McDonald Equipment Company ("McDonald Equipment") subscribed to a group health plan for its employees and their dependents (including Petitioners) through The Business Insurance Trust (the "BIT") in 1986, and the group health plan was underwritten by a group health policy issued by North Carolina Mutual Insurance Company ("NCM") and later by a group health policy issued by Provident Indemnity Life Insurance Company ("PILIC"). Arden French ("French") was the trustee of the BIT at all relevant times. Did the lower courts err in holding that the group health plan was an employee welfare benefit plan within the scope of the Employee Retirement Income Security Act of 1974, 28 U.S.C. § 1001, *et seq.* ("ERISA")?

2. Did the lower courts err in holding that Petitioners' state law claims sufficiently "relate to" the group health plan so the claims would be preempted by ERISA?

3. When McDonald Equipment originally subscribed to the group health plan, the group health plan was underwritten by a group health policy issued by NCM, and Insurance Resource Management ("IRM") (an administration company organized by French) was the third-party administrator for the plan. When NCM later indicated that it would be terminating the group health policy, French (as trustee of the BIT) sought to obtain replacement group health coverage, and he ultimately placed the coverage

QUESTIONS PRESENTED – Continued

with PILIC. PILIC's policy was a typical group health policy, and PILIC periodically adjusted premiums based upon an employer's loss history according to a tier-rating schedule (which was common in the industry). Did the lower courts err in finding that French (as trustee of the BIT) did not breach any fiduciary duties in placing the replacement coverage with PILIC?

4. Contrary to Petitioners' assertions, Respondents did not act as an insurance agent or broker for the group health plan, and Petitioners did not assert claims against Respondents in such capacity. Rather, Petitioners sued PILIC (as the insurer which underwrote the group health plan), French (as trustee of the BIT), and the BIT (the multiple employer trust through which Petitioners obtained coverage under the group health plan). Did the lower courts err in holding that Respondents (in such capacities) were ERISA fiduciaries?

5. Did the lower courts err in holding that there was no breach of fiduciary duty relating to the adjustment of premiums and handling of claims that resulted in a "loss to the plan" as required under ERISA?

LIST OF INTERESTED PERSONS OR ENTITIES

The following parties have an interest in the outcome of this case:

1. Nathan and Sharyl McDonald, Individually and as next Friends and Guardians of Nathan Neil McDonald, a Minor, and J. N. McDonald, Jr., Individually and d/b/a McDonald Equipment Company

   Represented by **David L. Sheller**
   Sheller & Sprain
   9 Greenway Plaza,
   Suite 3028
   Houston, Texas 77046
   (713) 961-0291
   (713) 961-5112 (Facsimile)

2. Provident Indemnity Life Insurance Company, Arden O. French, Jr., Trustee for The Business Insurance Trust and The Business Insurance Trust

   Represented by **Gene F. Creely, II**
   John H. Boswell
   Boswell & Hallmark, P.C.
   1100 Louisiana, Suite 2100
   Houston, Texas 77002
   (713) 650-1600
   (713) 650-1211 (Facsimile)

3. Provident American Corporation (parent company of Provident Indemnity Life Insurance Company)

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The group health plan constituted an employee welfare benefit plan under ERISA, and Petitioners' state law claims are preempted under ERISA 12

Petitioners' state law claims are clearly "related to" an ERISA plan; and, thus, those claims are preempted by ERISA 19

Petitioners did not assert any claims of wire fraud or mail fraud or RICO violations 21

French (as trustee of the BIT) did not breach any fiduciary duty in placing the replacement coverage with PILIC 22

Neither PILIC nor French breached any fiduciary duty to Petitioners relating to the setting of premiums or in the handling of the group health plan 26

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NOW COME Respondents PROVIDENT INDEMNITY LIFE INSURANCE COMPANY ("PILIC"), ARDEN O. FRENCH, JR. ("French"), AS TRUSTEE OF THE BUSINESS INSURANCE TRUST, and THE BUSINESS INSURANCE TRUST (the "BIT") (collectively, "Respondents") and submit this Brief in Opposition to Petition for Writ of Certiorari filed on behalf of Petitioners NATHAN AND SHARYL MCDONALD, INDIVIDUALLY AND AS NEXT FRIENDS AND GUARDIANS OF NATHAN NEIL MCDONALD, A MINOR, AND J. N. MCDONALD, JR., INDIVIDUALLY AND D/B/A MCDONALD EQUIPMENT COMPANY (collectively, "Petitioners").

REFERENCE TO OPINION BELOW

The Opinion of the United States Court of Appeals for the Fifth Circuit has been reported at *McDonald v. Provident Indemnity Life Ins. Co.*, 60 F.3d 234 (5th Cir. 1995). The Opinion of the United States District Court for the Southern District of Texas, Galveston Division, has not been published in the Federal Reporters.

STATEMENT OF JURISDICTION

The District Court rendered its Final Judgment on June 3, 1993. On appeal, the Fifth Circuit Court of Appeals rendered its Opinion on August 9, 1995. Petitioners timely filed their Motion for Rehearing, and the motion was denied on September 15, 1995. Petitioners submitted a Petition for Writ of Certiorari on December 14, 1995, which was not filed until January 22, 1996, after Petitioners' counsel was admitted to the bar of this Court.

In their Petition, Petitioners "invoke the jurisdiction of this Court pursuant to 28 U.S.C. § 1254(1)," and they suggest that this Court should grant the Petition to consider an alleged "split of authority" between courts of appeals relating to ERISA preemption of state law claims regarding fraudulent inducement by an insurance agent to participate in an "ERISA plan." Petitioners also suggest that there is an alleged "split of authority" between courts of appeals regarding the "status and duties of a fiduciary."

However, Petitioners have failed to "present with accuracy, brevity and clearness whatever is essential to a ready and adequate understanding of the points requiring consideration," and such failure is "sufficient reason for denying the petition." Supreme Court Rule 14.5. Petitioners also have failed to raise "special important reasons" for the granting of the Petition for Writ of Certiorari. Supreme Court Rule 10.1.

In any event, there is no "split of authority" between Courts of Appeals relating to the facts of this case (as suggested by Petitioners). Petitioners did not assert any claim of fraudulent inducement against an insurance agent, and there was no fraud perpetrated by Respondents (as suggested by Petitioners) that induced Petitioners into participating in the group health plan.

Excluding Petitioners' ERISA claims, Petitioners have not asserted any claims under federal law; Petitioners' state law claims clearly "relate to" the administration of an employee welfare benefit plan governed by ERISA; and, thus, Petitioners' state law claims would be preempted by ERISA. *See Pilot Life Ins. Co. v. Dedeaux*, 107 S.Ct. 1549, 1558 (1987).

Regarding Petitioners' ERISA claims, there was no breach of fiduciary duties by Respondents through the group health plan, and Petitioners failed to prove a "loss to the plan" as required by 29 U.S.C. § 1109(a). *See Massachusetts Mutual Life Ins. Co. v. Russell*, 105 S.Ct. 3085, 3089-3090 (1985). Also, Petitioners have not alleged that the Court of Appeals erred in holding that they failed to prove any "loss to the plan"; and, thus, Petitioners have failed to present this issue to this Court for review. *See Chandris, Inc. v. Latsis*, 115 S.Ct. 2172, 2182 fn. 1 (1995); *Kamen v. Kemper Financial Services, Inc.*, 111 S.Ct. 1711, 1716 fn. 4 (1991) (Ordinarily, the Supreme Court should not consider an issue that a Petitioner fails to raise in a Petition for Writ of Certiorari).

Accordingly, this Court should decline to exercise jurisdiction by granting the Petition for Writ of Certiorari in this case.

LIST OF RELEVANT STATUTES

Respondents assert that the following statutes are relevant to this Court's consideration of the issues in this case:

29 U.S.C. § 1002(1)

29 U.S.C. § 1104(a)

29 U.S.C. § 1109

29 U.S.C. § 1132(a)(1)

29 U.S.C. § 1144(a)

The statutes are quoted *verbatim* in Appendix I.

Contrary to Petitioners' assertions relating to "Constitutional and Statutory Provisions at Issue," neither the Texas Deceptive Trade Practices - Consumer Protection

Act ("DTPA"), § 17.46 *et seq.* of the Texas Business & Commerce Code, nor Article 21.21 of the Texas Insurance Code (cited by Petitioners) is relevant because Respondents did not commit any violations of these statutes, and ERISA preempts Petitioners' claims thereunder since the claims clearly "relate to" the administration of an employee welfare benefit plan governed by ERISA. Also, the federal "mail fraud statute," 18 U.S.C. § 1001 (cited by Petitioners), is not relevant because Petitioners did not assert any claim of "mail fraud" or "wire fraud" under the statute, and Respondents did not commit any "mail fraud" or "wire fraud." In addition, there was no "self dealing by alleged ERISA fiduciaries" in this case; and, thus, 29 U.S.C. § 1106 (cited by Petitioners) is also not relevant.

STATEMENT OF THE CASE

Relevant history of the group health plan.

The Business Insurance Trust (the "BIT") (a multiple employer trust) was established in 1968 as a vehicle for allowing small businesses (like McDonald Equipment Company ("McDonald Equipment")) to obtain group health coverage. (Tr.II 162-164; *see* Tr.I 96) Originally, Arden French ("French") was the trustee of the BIT (a dry trust which had a group health policy as its only asset) (Tr.II 127, 285), the group health plan was underwritten by group health policies issued by various insurers, and the insurers delegated the administration of the group health plan to Insurance Resource Management ("IRM") (an administration company organized by French) as a third-party administrator. (Tr.II 55-58, 163-167) IRM administered the BIT according to guidelines/procedures

specified by the insurer providing the coverage which underwrote the group health plan. (Tr.II 49) The BIT (a multiple employer trust) is a fairly common arrangement (Tr.II 253); it is not uncommon for the trustee (such as French) of a multiple employer trust to also own the administration company which administers the multiple employer trust (*Id.*); and this is a perfectly legitimate arrangement which is not proscribed in any state. (Tr.II 270)

In 1986, McDonald Equipment subscribed to the group health plan for its employees and their dependents (including Petitioners) through the BIT. (Tr.I 38) At the time of the subscription, the group health plan was underwritten by a group health policy written by North Carolina Mutual Insurance Company ("NCM") (*Id.*), and IRM continued to act as the third-party administrator of the group health plan. (Tr.I 49) Under the group health plan, McDonald Equipment paid the premiums for its employees and part of the premiums for their dependents (Tr.I 55), and the premiums for McDonald Equipment's group health coverage were adjusted every six months according to a class or tier re-rating structure. (Tr.I 233-235; Tr.II 61-63, 88-90) At the time of the subscription, Nathan McDonald (Manager of McDonald Equipment) acknowledged that **"this is a variable re-[r]ated trust which allows cases to be rated on a class basis based on claims experience, history, census data, medical costs, area rating, industry classification and health condition."** (Bold in original) (Ex. 3; Tr.I 76, 120)

During the relevant time, the premiums for group health coverage were commonly adjusted periodically according to a tier re-rating structure throughout the insurance industry. (Tr.II 90, 168, 180-181) Under a tier re-

rating structure, participating employers received premium increases periodically based upon whether their respective claims histories fell into certain pre-determined ranges of loss ratios (or tiers) for the preceding rating period. (Tr.II 88) The setting of the ranges of loss ratios and premium increases is determined by actuaries according to various factors including census data, medical costs, area rating, industry classification, health conditions and claims experience for the entire block of business (i.e., all of the participating employers in the group health plan). (Tr.II 171-172, 275)

In 1988, NCM notified French (as trustee for the BIT) that it intended to cancel its group health coverage which underwrote the group health plan. (Tr.II 172) Faced with this "emergency" situation, French was required to go into the marketplace and search for available replacement group health coverage, or else the participating employers (including McDonald Equipment) would be left without any group health coverage for their employees and their dependents. (Tr.II 70-71, 173-175; *see* Tr.II 208, 230, 245-246) French's main concern was to obtain replacement coverage for these employer groups. (Tr.II 208, 238) French contacted several interested insurers including Provident Indemnity Life Insurance Company ("PILIC"); he personally met with representatives of PILIC; he felt that PILIC (a solvent company with 102-year history) provided the best available replacement group health coverage under the circumstances; and, he placed the replacement group health coverage with PILIC effective August 1, 1988. (Tr.II 179-180, 229, 279)

French (as trustee of the BIT) had very limited duties which primarily involved insuring that appropriate coverage was maintained and holding the master policy for

the benefit of the participating employer groups. (Tr.II 168, 285) It is undisputed that French had no prior relationship with PILIC (Tr.II 175), and he received no remuneration or consideration for the placement of the replacement group health coverage with PILIC. (Tr.II 176)

In the health industry, there are rarely identical group health policies provided by different insurers. (Tr.II 180, 277) However, the PILIC group health policy provided substantially similar coverage to the group health coverage under the preceding NCM policy. (Tr.II 276; *see* Tr.II 146-159, 193-198, 281; *compare* Ex. 1 and Ex. 2) Both policies provided the same basic major medical benefits (with only minor differences), and the policy limits and deductibles were the same. (*Id.*) Also, the premiums for the group health coverage under the PILIC policy were to be adjusted based upon a participating employer's claims history under a tier re-rating structure in "basically the same way" that premiums were adjusted for group health coverage under the NCM policy. (Tr.II 61, 80, 180, 223; *see* Tr.I 194)

French had no responsibility for pricing/re-rating of premiums for group health coverage under the group health plan. (*See* Tr.I 219) Rather, re-rating (which is actuarially determined) was solely within the province of the insurer which underwrote the group health plan. (*Id.*) Also, information about the basis for re-rating premiums was customarily not furnished to covered persons, as such information is proprietary and there are a number of practical reasons why such information is not customarily disclosed (*e.g.*, an insurer may change its re-rating structure, the insurer may cancel its group coverage and a

succeeding insurer may adopt a different re-rating structure, any disclosure would defeat an insurer's competitive advantage since re-rating is determined in the free market, agents might be subject to liability for disclosure, etc.). (Tr.II 105, 224-225; Tr.III 2-3)

After PILIC began underwriting the group health plan, the premiums for the group health coverage were adjusted every six months according to a tier re-rating structure (as they had been adjusted in the past when the group health plan was underwritten by the NCM policy) (Tr.II 105, 224-225; Tr.III 2-3), and McDonald Equipment began receiving periodic increases in the premiums for the group health coverage for its employees and their dependents upon such basis (as they had been adjusted in the past when the group health plan was underwritten by the NCM policy). (Tr.I 72)

On September 15, 1989, Neil McDonald (the minor child of Nathan and Sharyl McDonald) suffered injuries in a near-drowning accident (Tr.I 40), and Petitioners incurred substantial medical expenses for the treatment of their minor child following the accident. (*See, e.g.*, Tr.II 151) Based upon the claims history of McDonald Equipment (which included the medical expenses for Neil McDonald), the premiums for McDonald Equipment's group health coverage for its employees and their dependents under the PILIC policy were subsequently adjusted under the class or tier re-rating structure (as they had previously been adjusted in the past). (Tr.I 79-80)

Shortly after the accident, French ceased to be the trustee of the BIT in November 1989, and his limited duties as trustee were transferred to three individuals and subsequently to TrustMark Bank of Jackson, Mississippi. (Tr.II 122-124, 183) Also, the situs of the BIT was

transferred from Georgia to Mississippi. (Tr.II 116) At this time, PILIC also acquired the business under the BIT which had been handled by IRM (the administration company organized by French) in exchange for a certain amount of cash, shares of Provident American Corporation (the parent company of PILIC) and a small overriding royalty on future premiums; and, the administrative responsibilities of the group health plan were transferred from IRM to in-house at PILIC. (Tr.II 182-187) French later became a director of Provident American Corporation (the parent company of PILIC). (Tr.II 21)

The timing of the transfer of the trustee duties, the transfer of the administration of the group health plan and the transfer of the situs of the BIT (approximately two months after the subject accident) was merely coincidental, since French was unaware of the subject accident at the time. (Tr.II 188) Also, the transfer of the trustee duties, the transfer of the administration of the group health plan and the transfer of the situs of the BIT did not effect any change in the group health coverage under the PILIC policy or any change in the handling of claims under the PILIC policy. (Tr.II 184-186, 284)

The first post-accident premium adjustment for McDonald Equipment occurred in February 1990, with subsequent adjustments in August 1990 and February 1991. (Tr.I 79-80, 283) Following these adjustments, McDonald Equipment made the conscious decision to discontinue paying premiums for the group health coverage for its employees and dependents under the group health plan in February or March 1991 (Tr.I 41, 66); and, McDonald Equipment's group health coverage for its employees and their dependents terminated effective

March 31, 1991 as a result of non-payment of premiums. (Tr.I 64; Tr.II 145)

It is undisputed that PILIC paid approximately $360,000.00, which represented all benefits for claims under the PILIC policy for covered medical expenses incurred by Petitioners through March 31, 1991 (the date of termination of coverage).[1] (Ex. 41; Tr.II 145; *see* Tr.I 64, 119, 174)

Relevant history of this litigation.

Subsequently, Petitioners filed this lawsuit against PILIC, French (as trustee of the BIT) and the BIT relating to the placement of the group health coverage with PILIC, the adjustment of premiums and the handling of claims under the group health plan. (R.I 1-6) Petitioners alleged various claims under state law (including claims of breach of contract, breach of fiduciary duty, breach of the duty of good faith and fair dealing, fraud and violations of the Texas Deceptive Trade Practices – Consumer Protection Act ("DTPA") and Article 21.21 of the Texas Insurance Code). (*Id.*) (R.III 434-462) In the alternative, Petitioners alleged claims under ERISA. (*Id.*)

Before trial, the District Court granted partial summary judgment that the group health plan was an employee welfare benefit plan within the scope of ERISA and that Petitioners' state law claims were preempted by

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[1] At the time of the termination of the coverage (due to nonpayment of premiums), there were potentially $640,486.90 in remaining limits for benefits over the lifetime of Neil McDonald. (Tr.II 33) However, those remaining limits ceased to be available to Petitioners upon the termination of coverage. (Ex. 1)

ERISA. (R.III 695-702) After the conclusion of trial, the District Court rendered Findings of Fact and Conclusions of Law in favor of Respondents. (R.IV 936-947) Basically, the District Court found that (1) French (as trustee of the BIT) did not act arbitrarily and capriciously in the placement of the group health coverage with PILIC, (2) neither PILIC nor French (as trustee of the BIT) breached any fiduciary duties relating to the setting of premiums or the handling of the administration of the group health plan and (3) thus, Respondents were not liable to Petitioners for damages under ERISA. (*Id.*) Accordingly, the District Court rendered a Final Judgment for Respondents. (R.IV 949)

On appeal, the Fifth Circuit Court of Appeals affirmed. In pertinent part, the Court of Appeals held that (1) McDonald Equipment's subscription to the group health plan through the BIT (a multiple employer trust) constituted an employee welfare benefit plan governed by ERISA, (2) Petitioners' state law claims were preempted by ERISA, (3) French did not breach any fiduciary duty in the placement of the group health coverage with PILIC, and (4) even if French had a duty to disclose the PILIC re-rating schedule, Petitioners failed to prove any "loss to the plan" as a result of such nondisclosure as required by 29 U.S.C. § 1109(a). *McDonald v. Provident Indemnity Life Ins. Co.*, 60 F.3d 234, 235-238 (5th Cir. 1995).

REASONS WHY THE PETITION SHOULD BE DENIED

The group health plan constituted an employee welfare benefit plan under ERISA, and Petitioners' state law claims are preempted under ERISA.

ERISA defines an employee welfare benefit plan as follows:

> . . . any plan, fund or program . . . established or maintained by an employer or by an employee organization, or by both, to the extent that such plan, fund or program was established or is maintained for the purpose of providing for its participants or their beneficiaries, the purchase of insurance or otherwise, . . . medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability, death or unemployment . . .

29 U.S.C. § 1002(1). By its terms, ERISA encompasses employee welfare benefit plans provided through the purchase of insurance. *Id.* Moreover, it is common practice for employers to provide health benefits to their employees through the purchase of group health policies from commercial insurers (such as PILIC). *Memorial Hospital System v. Northbrook Life Ins. Co.*, 904 F.2d 236, 240 (5th Cir. 1990). Furthermore, a formal document designated as "the plan" is not required to establish that an employee welfare benefit plan provided through the purchase of insurance under ERISA exists. *Id.* at 241.

An employee welfare benefit plan under ERISA is established and maintained "if from the surrounding circumstances a reasonable person can ascertain the intended benefits, a class of beneficiaries, the source of financing, and procedures for receiving benefits." *See Gahn v. Allstate Life Ins. Co.*, 926 F.2d 1449, 1452 (5th Cir. 1991); *Memorial Hospital System*, 904 F.2d at 240, quoting

Donovan v. Dillingham, 688 F.2d 1367, 1373 (11th Cir. 1982) (*en banc*).

Contrary to Petitioners' assertions, the group health policy issued by PILIC clearly was "insurance"[2] and, the group health plan (which was underwritten by the PILIC policy) qualified as an employee welfare benefit plan under ERISA, since McDonald Equipment intended to provide health benefits through the group health plan for its employees and their dependents. *Id.*

Specific health benefits were provided to a class of beneficiaries – the employees and dependents of McDonald Equipment. (*Id.*; *also*, R.II 299) Also, the source of financing was provided by McDonald Equipment

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[2] The group health policy issued by PILIC was a basic comprehensive major medical health insurance policy (Ex. 1; Tr.II 170, 179). At trial, Joe Hawkins (a former Commissioner of the State Board of Insurance of Texas) confirmed that the PILIC policy constituted insurance. (Tr.II 273) Robert Jaffe (Petitioners' insurance agent) also confirmed that the PILIC policy was insurance (Tr.I 108) Furthermore, it is clear that, assuming Petitioners' definition of insurance as "a spreading of the risk," the PILIC policy constituted insurance. (*See* Tr.I 224-228) The evidence shows that, although McDonald Equipment paid a few thousand dollars a month in premiums for post-accident group health coverage for its employees and their dependents (including Neil McDonald), PILIC paid approximately $360,000 in medical benefits for Neil McDonald alone (Tr.I 189; Tr.II 271).

Also, several witnesses discussed the inherent fairness and reasonableness of tier re-rating as a basis for periodic adjustment of premiums for group health coverage. (Tr.II 190, 271-272) In addition, tier-rating does not allow an insurer to recoup all claims paid (as suggested by Petitioners) (Tr.II 271) Furthermore, the group health coverage afforded by PILIC did "protect" Petitioners against this "large loss" (contrary to Petitioners' assertion). (*See* Tr.II 189, 271)

(which paid the premiums for its employees and a substantial portion of the premiums for their dependents through payroll deductions). (*Id.*) *See Memorial Hospital System*, 904 F.2d at 241 (where the employer contributed one-half of the total premium through payroll deductions, clear intent was found on the employer's part to provide its employees with a welfare benefit plan). *See also Randol v. Med-West National Life Ins. Co. of Tennessee*, 987 F.2d 1547 (11th Cir. 1993); *International Resources, Inc. v. New York Life Ins. Co.*, 950 F.2d 294 (6th Cir. 1991). In addition, the record clearly shows that McDonald Equipment (as employer) determined the benefits to be offered (including the decision to raise the deductible for the group health coverage from $100 to $500 following the first post-accident premium adjustment) (R.II 282-283, 296, 307); McDonald Equipment undertook the responsibility for notifying PILIC of employees who should be added or deleted from the group health plan (R.II 288-290, 300); and, McDonald Equipment provided enrollment forms to new employees. (R.II 302) Moreover, the procedure for claiming benefits required employer involvement in the group health plan. Nate McDonald (manager of McDonald Equipment) was responsible for coordinating the participation of the employees of McDonald Equipment and their dependents in the group health plan (R.II 286-288, 301); management was responsible for distributing wallet identification cards, enrollment and claim forms (R.II 284, 288-290, 297-298, 300, 302); and, furthermore, the section "How to File a Medical Claim" found in the PILIC insurance certificate requires portions of any claim form to be completed by both the employer and employee (R.II 418), and PILIC

also required McDonald Equipment (as employer) to verify the employment and dependency status of individuals applying for benefits (R.II 288-290, 300).

Petitioners assert that J. N. McDonald (the owner of McDonald Equipment) understood that McDonald Equipment merely "bought an insurance policy with competitive rates" and that there was no intention to establish or maintain an employee welfare benefit plan under ERISA, and McDonald Equipment did not comply with any ERISA reporting requirements. However, McDonald Equipment's subjective intent and its noncompliance with the ERISA reporting requirements are irrelevant to the determination of the existence of an employee welfare benefit plan under ERISA. The "test of whether a benefit plan is exempt from ERISA is not one of the employer's motivation" and "an employer cannot 'opt out' of ERISA by noncompliance." *Marshall v. Bankers Life and Casualty Co.*, 832 P.2d 573, 581 (Cal. 1992) (*en banc*), citing *Shaw v. Delta Airlines, Inc.*, 103 S.Ct. 2890-2905 (1983). Rather, the existence of an employee welfare benefit plan under ERISA is to be determined by the surrounding facts and circumstances (not by statements of an employer's subjective intent) according to the relevant factors articulated in the *Gahn, Memorial Hospital System* and *Donovan* cases. *See Randol*, 987 F.2d at 1549 (applying *Donovan* factors, group health coverage purchased by an employer for his employees was an employee welfare benefit plan governed by ERISA despite the employer's testimony that he did not intend to create an ERISA plan, and he did not comply with any ERISA reporting requirements); *International Resources*, 950 F.2d at 297 (applying *Donovan* factors, group health coverage purchased by an employer for his

employees was an employee welfare benefit plan governed by ERISA despite the employer's contention that he did not intend to create an ERISA plan).

Petitioners also assert that a multiple employer trust is not an employee welfare benefit plan under ERISA and that, since the group health plan involved a multiple employer trust, the group health plan could not be an employee welfare benefit plan under ERISA based upon *Taggart Corp. v. Life & Health Benefits Administration*, 617 F.2d 1208 (5th Cir. 1980), cert. denied, 101 S.Ct. 1739 (1981).

It is true that a multiple employer trust is not, in and of itself, an employee welfare benefit plan. *Taggart*, 617 F.2d at 1211. However, a group health plan is not exempt from ERISA simply because a multiple employer trust is connected in some manner with the plan. *Memorial Hospital System*, 904 F.2d at 242, *see Donovan*, 688 F.2d at 1374-75; *see also, Meredith v. Time Ins. Co.*, 980 F.2d 352, 354 (5th Cir. 1993) (a court should not simply be concerned whether there exists a multiple employer trust, but whether the purchase of insurance from the multiple employer trust constitutes the establishment or maintenance of an employee welfare benefit plan). Thus, Petitioners' reliance upon the *holdings* in *Taggart* is misplaced.

Petitioners' reliance upon the *facts* of *Taggart* is also misplaced. In *Taggart*, a company obtained group health coverage through a multiple employer trust for its president/sole employee and his family. Asserting that the multiple employer trust itself was an employee welfare benefit plan under ERISA, the company and its president/sole employee brought suit under ERISA against the group health insurer to recover health benefits allegedly owing to his wife. However, the Court held that

the "bare purchase of insurance" under the multiple employer trust for the president/sole employee and his family did not establish the existence of an employee welfare benefit plan under ERISA. *Taggart*, 617 F.2d at 1211; *see also Fugarino v. Hartford Life & Accident Ins. Co.*, 969 F.2d 178 (6th Cir. 1992) (a group health plan whose sole beneficiaries are a proprietor and his dependents cannot qualify as an employee welfare benefit plan under ERISA).

The holdings of *Taggart* were subsequently limited by the Court in *Memorial Hospital System* (which is factually indistinguishable from this case). In *Memorial Hospital System*, the Court noted that, unlike *Taggart*, that case did not involve the bare purchase of insurance by the president/sole employee of a company through a multiple employer trust. Rather, the employer had chosen to provide health benefits to all of its full-time employees through a multiple employer trust underwritten by a group health policy, and the employer was responsible under the group health policy for paying monthly premiums. The Court also noted that "the fact that [employer's] administrative functions under the policy were minimal was perfectly in keeping with its intent that [the insurer] administer the plan as well as insure it," and "there is, thus, an employer-employee plan relationship that was lacking in *Taggart*." *Memorial Hospital System*, 904 F.2d at 243; *see also Perkins v. Time Ins. Co.*, 701 F.Supp. 576, 577-78 (S.D. Miss. 1988). The Court then upheld a summary judgment that an employee welfare benefit plan had been established and maintained under ERISA since, from the summary judgment evidence, a reasonable person could ascertain the intended benefits under the group health plan, a class of plan beneficiaries, the source of

financing for the plan, and procedures for receiving benefits under the plan. *Memorial Hospital System*, 904 F.2d at 243.

Based upon *Memorial Hospital System* (which involved virtually identical facts to the facts of this case), Respondents assert that the Court of Appeals properly upheld the summary judgment that the group health plan constituted an employee welfare benefit plan under ERISA since a reasonable person could ascertain the intended benefits under the group health plan, the class of the plan beneficiaries, the source of financing for the plan, and procedures for receiving benefits as a matter of law.[3]

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[3] In addition, Petitioners assert that the group health plan is an "entrepreneurial venture" which would not be protected as an employee welfare benefit plan under ERISA. However, the group health plan is not an "entrepreneurial venture." *Compare Hamberlin v. VIP Ins. Trust*, 343 F.Supp. 1196, 1198 (D.C. Ariz. 1977) (without placing the business with an authorized insurer after an insurer cancelled its group health insurance coverage which underwrote a multiple employer trust, insurance brokers established a self-funded trust for providing limited health benefits but not extended benefits, the brokers acted as administrators of the fund for a 15% commission and this arrangement was purely an "entrepreneurial plan" to protect the business commissions they would have lost if the trust had not been restructured and continued after the insurer cancelled its group health coverage); *see Memorial Hospital System*, 904 F.2d at 242-243.

Petitioners also assert that, since J. N. McDonald was the sole proprietor of McDonald Equipment, an employee welfare benefit plan under ERISA could not be established for the purchase of insurance through a multiple employer trust and that, since a sole proprietor cannot qualify as an ERISA participant because he cannot be both employer and employee, ERISA cannot pre-empt J. N. McDonald's claims. However, J. N. McDonald's status as sole proprietor of McDonald Equipment

Memorial Hospital System, 904 F.2d at 243; *Donovan*, 688 F.2d at 1373. Furthermore, since McDonald Equipment established and maintained an employee welfare benefit plan under ERISA, Petitioners' state law claims are pre-empted under ERISA. *Metropolitan Life Ins. Co. v. Taylor*, 107 S.Ct. 1542 (1987); *Pilot Life Ins. Co. v. Dedeaux*, 107 S.Ct. 1549, 1553 (1987); *Memorial Hospital System*, 904 F.2d at 245; *Ramirez v. Inter-Continental Hotels*, 890 F.2d 760, 762 (5th Cir. 1989).

Petitioners' state law claims are clearly "related to" an ERISA plan; and, thus, those claims are preempted by ERISA.

For the first time on appeal, Petitioners have now asserted that ERISA should not pre-empt their "state law claims of fraud in the inducement, deceptive trade practices and fraud employed by insurance agents and brokers to induce the purchasers of insurance and/or ERISA plans." However, neither PILIC nor French (or the BIT) was the insurance agent or broker for the group health plan, and Petitioners did not sue them in such capacity. Also, there was no fraud inducing Petitioners into the

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or as an "ERISA participant" is immaterial, since the claims belong to Nathan and Sharyl McDonald (as the parents of Neil McDonald) as a result of the medical expenses incurred by them while the group health insurance coverage under the PILIC policy was in effect, and J. N. McDonald has no standing relative to those claims. *See Christopher v. Mobil Oil Corp.*, 950 F.2d 1209 (5th Cir. 1991), cert. denied, 113 S.Ct. 68 (1992) (the plaintiff in an ERISA action must be a "participant" (or an employee or former employee who is or may be eligible to receive the benefits in dispute under an ERISA plan); *compare Meredith v. Time Ins. Co.*, 980 F.2d 352 (5th Cir. 1993); *Fugarino v. Hartford Life & Accident Ins. Co.*, 969 F.2d 178 (6th Cir. 1992).

plan at the time of the placement of replacement coverage with PILIC, since Petitioners had already been participating in the group health plan for several years. In addition, Respondents have failed to raise this issue before the Court of Appeals; and, thus, they have failed to preserve any error (if any). *See Singleton v. Wulff*, 96 S.Ct. 2868, 2877 (1976); *Youakim v. Miller*, 96 S.Ct. 1399, 1401 (1976) (Ordinarily the Supreme Court should not decide questions not raised or resolved in the lower courts).

In any event, Petitioners' state law claims (including fraud claims) clearly "relate to" an ERISA plan. This Court has dealt with the scope of ERISA pre-emption on numerous occasions. ERISA preempts "any and all state laws insofar as they may now or hereafter relate to any employee benefit plan described in § 1003(a) of this title and not exempt under § 1003(b) of this title." 29 U.S.C. § 1144(a). A state law "relate[s] to" an ERISA plan "if it has connection with or reference to such a plan." *District of Columbia v. Greater Washington Board of Trade*, 113 S.Ct. 580, 583 (1992); *Shaw v. Delta Airlines, Inc.*, 103 S.Ct. 2890, 2900 (1983). The "deliberately expansive" language of the pre-emption clause is "designed to establish pension plan regulation as exclusively a federal concern." *Ingersol Rand Co. v. McClendon*, 111 S.Ct. 478, 482 (1990); *Pilot Life Ins. Co. v. Dedeaux*, 107 S.Ct. 1549, 1555-57 (1987). Under § 514(a), ERISA preempts any state law that refers to or has a connection with ERISA plans (if it does not fall within § 514(b) exception) "even if the law is not specifically designed to effect such plans, or the effect is only indirect," 29 U.S.C. § 1144(a); *see District of Columbia v. Greater Washington Board of Trade*, 113 S.Ct. at 583; *Ingersol Rand Co. v. McClendon*, 111 S.Ct. at 483, and even if the

law is "consistent with ERISA's substantive requirements." *Metropolitan Life Ins. Co. v. Massachusetts*, 105 S.Ct. 2380, 2389 (1985).

As noted above, Petitioners asserted various claims under state law (including claims of breach of contract, breach of fiduciary duty, breach of the duty of good faith and fair dealing, fraud and violations of the Texas DTPA and Texas Insurance Code), and all of these state law claims related to the placement of the replacement coverage with PILIC or the setting of premiums and the handling of claims in the group health plan. (R.III 434-462)

Clearly, Petitioners' state law claims "relate to" the administration of the group health plan; and, as such, those claims clearly have "a connection with or reference to such a plan." *See Ingersol Rand Co. v. McClendon*, 111 S.Ct. at 483-484 (state law claim that an employer wrongfully discharged employee to avoid paying benefits under employees' pension fund "relates to" ERISA plan and therefore is preempted by ERISA); *FMC Corp. v. Holliday*, 111 S.Ct. 403, 407-409 (1990) (ERISA preempted application of state anti-subrogation law which precluded reimbursement from a claimant's tort recovery for benefit payments paid under an ERISA plan); *Pilot Life Ins. Co. v. Dedeaux*, 107 S.Ct. at 1558 (state law claim of bad faith relating to improper processing of a claim for benefits under an ERISA plan is preempted). Accordingly, the lower courts did not err in holding that ERISA preempted Petitioners' state law claims.

Petitioners did not assert any claims of wire fraud or mail fraud or RICO violations.

Petitioners suggest that PILIC and French committed wire fraud, mail fraud and RICO violations under federal

law and that "the Fifth Circuit's Opinion fails to address how PILIC's violation and French's violation of other state and federal laws can be preempted by ERISA." However, Petitioners' claims of violations of state law are preempted by ERISA (as noted above). Furthermore, Petitioners did not assert any claims for wire fraud, mail fraud or RICO violations under federal law (R.II 434-462), and neither PILIC nor French committed any wire fraud, mail fraud or RICO violations under federal law. Since Petitioners did not assert any claims of wire fraud, mail fraud or RICO violations, there is nothing presented for this Court to review. *See Usery v. Turner Elkhorn Mining Co.*, 96 S.Ct. 2882, 2902-2903 (1976) (where claim was never asserted in the District Court, it would be inappropriate for the Supreme Court to consider the merits of the claim).

French (as trustee of the BIT) did not breach any fiduciary duty in placing the replacement coverage with PILIC.

The BIT trust agreement basically provided French (as trustee of the BIT) with the discretion in selecting and maintaining the group health coverage to be provided through the BIT (Ex. 4, Article VII). In fulfilling his duties as an ERISA fiduciary, French owed a duty to all beneficiaries (and not just to individual beneficiaries) under the group health plan. *Williams v. Caterpillar, Inc.*, 944 F.2d 658 (9th Cir. 1991). In this case, French (as trustee of the BIT) did not breach any fiduciary duty in placing the replacement coverage with PILIC.

When he was faced with the "emergency" situation prompted by NCM's notice of intent to terminate its group coverage, French conducted an immediate search

for insurers to place the "block of business" (including approximately 4,000 certificate holders) so there would be continuing coverage under the group health plan. (Tr.II 172-173, 176-177) After interviewing several insurers, French decided to place the replacement coverage with PILIC. (Tr.II 176, 229) At that time, he could not find any closer coverage to the coverage afforded under the NCM policy (Tr.II 180), he understood that coverage under the PILIC policy was going to be tier-rated (which was common in the insurance industry) "just like everyone else based on losses"[4] (*Id.*), and PILIC was an established company (102 years old) which was interested in expanding its business in this area. (Tr.II 176, 179) It is undisputed that French had no pre-existing relationship with PILIC, and he did not receive any compensation (cash, stock, etc.) as a result of the placement of the replacement coverage with PILIC, although PILIC allowed IRM (the administration company organized by French) to handle the administration of the group health plan (a common practice in the industry) for a set fee (Tr.II 175-176).

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[4] Incidentally, French and his family as well as the employees and dependents of IRM (the administration company organized by French) were also provided the same coverage under the group health plan and were subject to the same re-rating of premiums formula, and their premiums were adjusted according to the tier re-rating structure by NCM and, later, PILIC (Tr.II 174-175, 250-251).

Also, contrary to Petitioners' assertion, French did not testify that PILIC's tier rating schedule was designed to force small businesses (like McDonald Equipment) to drop their coverage if they experienced a catastrophic loss (Tr.II 198), the Koppel & Co. report did not advocate this "policy," (Ex. 8) and PILIC did not rely upon the Koppel & Co. report relative to tier rating for the group health plan. (Tr.I 235, 237)

Contrary to Petitioners' suggestion, French did not choose PILIC only because they were willing to allow IRM to administer the group health plan; rather, he chose PILIC because they were willing to accept the "block of business" (including approximately 4,000 certificate holders at the time) (Tr.II 207-208), and PILIC provided the best available replacement coverage under the circumstances (Tr.II 178). Also, French timely notified all certificate holders (including Petitioners) regarding the change in coverage. (Ex. 61) In any event, PILIC was (and remains) solvent, and PILIC paid all of Petitioners' covered claims. (Tr.II 247)

Under the circumstances, French (as trustee of the BIT) did not breach any fiduciary duty owed to the plan in placing the replacement coverage with PILIC. *See Williams*, 944 F.2d at 664-665 (pension and medical plan managers did not breach their fiduciary duties by offsetting accrued retirement benefits following change in certain former employee's employment status; and, former employees, who did not ever request any plan description, could not seek damages for alleged failure of plan managers to furnish plan descriptions); *United Paper Workers International Union AFL-CIO, CLC v. Jefferson Smurfit Corp.*, 771 F.Supp. 992 (E.D. Mo. 1991) (employers did not breach their fiduciary duty in increasing retirees' group medical premiums and reducing medical benefits where plan reserved to employers the right to modify the plan).

Petitioners continue to accuse French of having a conflict of interest when he placed the replacement coverage with PILIC because IRM (the administration company organized by French) was allowed to administer the

group health plan (for which IRM received a commission), and when he assigned his trustee duties to three individuals (PILIC employees) and sold the business under the BIT handled by IRM to PILIC.

A fiduciary charged with self-dealing in a group health plan must either prove by a preponderance of evidence that the transaction in question fell within an exemption, or he must prove by clear and convincing evidence that compensation received was for services rather than for transactions involving assets of the plan. *Lowen v. Tower Asset Management, Inc.*, 829 F.2d 1209 (2nd Cir. 1987); *Wildbur v. Arco Chemical Co.*, 74 F.2d 631 (5th Cir. 1992), reh'g denied, 979 F.2d 1013 (5th Cir. 1992); *Salley v. E.I. DuPont de Nemours & Co.*, 966 F.2d 1011 (5th Cir. 1992); *Vassuer v. Haliburton Co.*, 950 F.2d 1002 (5th Cir. 1992). However, a fiduciary is not subject to liability under ERISA if he terminates his relationship with the plan before playing any role in transactions otherwise denied to fiduciaries by ERISA. *Id.* at 1219.

As noted above, French (as trustee of the BIT) had no pre-existing relationship with PILIC, and he received no consideration when he placed the replacement group health coverage with PILIC in 1988. (Tr.II 175) However, PILIC (like NCM) did allow IRM (the administration company organized by French) to continue to act as third-party administrator for the group health plan (a common industry practice) for a set fee. (Tr.II 21) Later, in 1989 (about one and a half years later), PILIC acquired the business under the BIT handled by IRM (the administration company organized by French) for cash and stock in Provident American Corporation (the parent company of PILIC). (Tr.II 186, 213) French was later appointed to the

Board of Directors of Provident American Corporation. (Tr.II 21) However, this transaction occurred after French resigned as trustee and assigned his trustee duties to three individuals (which were later assigned to a trust bank); and, after PILIC acquired IRM, the situs of the BIT was moved from Georgia to Mississippi, and the administration of the group health plan was transferred from IRM (a third-party administrator) to in-house at PILIC (which is not uncommon). (Tr.II 182-189) These subsequent transactions (which occurred about one and a half years after the placement of the replacement coverage with PILIC) had no effect on French's decision to place the replacement coverage with PILIC (*Id.*), and the transactions did not effect any change in coverage under the group health plan or any change in the handling of the claims. (*Id.*)

Under the circumstances, French did not have a conflict of interest when he placed the replacement group health coverage with PILIC in 1988. Also, IRM was clearly compensated for "services other than transactions involving assets of the plan," and French has no liability for breach of fiduciary duty under ERISA since he terminated his relationship in the plan before selling the business under the BIT handled by IRM to PILIC.

Neither PILIC nor French breached any fiduciary duty to Petitioners relating to the setting of premiums or in the handling of the group health plan.

Petitioners basically assert that PILIC and French breached their fiduciary duty in failing to disclose to them the basis upon which premiums would be adjusted. However, the record shows that tier re-rating was commonly employed by many insurers at the time to adjust

premiums under similar group health plans (Tr.II 90, 168, 180-181), tier re-rating is both fair and reasonable (Tr.II 190, 271-272), both PILIC and French understood that NCM had employed class or tier re-rating in adjusting the premiums for the similar group health coverage under the NCM policy (Tr.II 61, 80, 180, 223), and PILIC was probably more lenient than NCM in re-rating (Tr.II 67-68). In addition, there are a number of practical reasons why re-rating information is not disclosed to policy holders (Tr.II 105, 224-225; Tr.III 2-3), and it is not common for marketing and administration personnel to disclose an insurer's rating system (which is proprietary). (Tr.II 303) Contrary to Petitioners' assertion, the tier re-rating structure employed by PILIC (and NCM) did not "pick on any one particular [employer] group to knock them out of a plan. [All employer groups were] treated identically the same insofar as rating was concerned." (Tr.II 198-199) In addition, tier re-rating "does not work to allow an insurer to ultimately recoup all of claims paid" (Tr.II 271), and PILIC did not recoup all of the claims it paid (Petitioners were paid approximately $360,000.00 in benefits for Neil McDonald, whereas McDonald Equipment paid only a few thousand dollars per month in post-accident premiums for all of its employees and their dependents (including Petitioners)). (Tr.II 271-272; *also,* Tr.I 189)

Petitioners also continue to complain that French misrepresented that the PILIC policy was an "assumption" of the NCM policy. However, it is undisputed that PILIC's policy was never advertised as an "assumption" of the NCM policy (but was clearly a new replacement policy). (Tr.II 279-280) In addition, French and PILIC never committed to duplicate NCM's coverage, and the

PILIC policy provided substantially similar coverage (with only insignificant differences) (as noted above).

Petitioners also complain about the transfer of the trustee duties (and benefit committee) from French to three individuals (and later to a trust bank), the transfer of the administration of the group health plan from IRM to in-house at PILIC and the transfer of the situs of the BIT from Georgia to Mississippi. However, it is not uncommon for an insurer to administer its own claims in-house, and PILIC wanted control of the administration of the group health plan to better serve its employer groups. (Tr.II 122-124, 182-186) In addition, the transfer of administrative duties from IRM to PILIC did not effect any change in coverage; there was improvement in the servicing of the claims following the transfer of administrative duties; the transfer of the trustee duties (and benefit committee) did not effect any change in coverage; and, the transfer of the situs of the trust also did not effect any change in coverage. (*Id.*) Furthermore, the record shows that all of Petitioners' claims through the date of the termination of coverage (March 31, 1991) were paid. (Ex. 41; Tr.II 145; *see* Tr.I 64, 119, 174)

Petitioners continue to note French's failure to appoint two members to the Benefit Committee. However, this failure was inconsequential, because the PILIC policy provided (and continues to provide) substantially similar coverage to the coverage afforded under the NCM policy through the BIT. (Tr.II 276; *see* Tr.II 146-159, 193-198, 281)

Accordingly, Respondents assert that the lower courts did not err in holding that neither PILIC nor French breached any fiduciary duty owed to Petitioners in this case. *See Williams*, 944 F.2d at 664-667.

Petitioners did not show any breach of any fiduciary duty which resulted in a "loss to the plan" as required by § 1109(a).

As noted above, the Court of Appeals held that, even if French had an obligation to disclose PILIC's re-rating schedule, Petitioners failed to prove a "loss to the plan" as required by 29 U.S.C. § 1109(a). *McDonald v. Provident Indemnity Life Ins. Co.*, 60 F.3d at 237. The Court of Appeals noted that, in *Massachusetts Mutual Life Ins. Co. v. Russell*, 105 S.Ct. 3085, 3089-90 (1985), this Court interpreted the "loss to the plan" language in § 1109 to limit claims of breach of fiduciary duty to those which inured to the benefit of the plan as a whole rather than to individual beneficiaries.

Clearly, French (as trustee of the BIT) did not breach any fiduciary duties "to the benefit of the plan as a whole rather than to individual beneficiaries," and there was no "loss to the plan" which is required for any claim of breach of fiduciary duty under § 1109. *See Massachusetts Mutual Life Ins. Co. v. Russell*, 105 S.Ct. at 3089-90.

In any event, Petitioners have not raised this issue in their Petition; and, thus, Petitioners have waived any resulting error (if any). *See Chandris, Inc. v. Latsis*, 115 S.Ct. 2172, 2182 fn. 1 (1995).

CONCLUSION

Absent any "special and important reasons" and any error committed by the lower courts, *see* Supreme Court Rule 10.1, this Court should decline to exercise jurisdiction over this case and should deny the Petition for Writ of Certiorari.

Respectfully submitted,

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APPENDIX I

RELEVANT STATUTES

§1002. Definitions

For purposes of this subchapter:

(1) The terms "employee welfare benefit plan" and "welfare plan" mean any plan, fund, or program which was heretofore or is hereafter established or maintained by an employer or by an employee organization, or by both, to the extent that such plan, fund or program was established or is maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, (A) medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability, death or unemployment, or vacation benefits, apprenticeship or other training programs, or day care centers, scholarship funds, or prepaid legal services, or (B) any benefit described in section 186(c) of this title (other than pensions on retirement or death, and insurance to provide such pensions).

§1104. Fiduciary duties

(a) Prudent man standard of care

(1) Subject to sections 1103(c) and (d), 1342, and 1344 of this title, a fiduciary shall discharge his duties with respect to a plan solely in the interest of the participants and beneficiaries and –

(A) for the exclusive purpose of:

(i) providing benefits to participants and their beneficiaries; and

(ii) defraying reasonable expenses of administering the plan;

(B) with the care, skill prudence, and diligence under the circumstances then prevailing that a prudent man acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims;

(C) by diversifying the investments of the plan so as to minimize the risk of large losses, unless under the circumstances it is clearly prudent not to do so; and,

(D) in accordance with the documents and instruments governing the plan insofar as such documents and instruments are consistent with the provisions of this subchapter or subchapter III of this chapter.

§1109. Liability for breach of fiduciary duty

(a) Any person who is a fiduciary with respect to a plan who breaches any of the responsibilities, obligations, or duties imposed upon fiduciaries by this subchapter shall be personally liable to make good to such plan any losses to the plan resulting from each such breach, and to restore to such plan any profits of such fiduciary which have been made through use of assets of the plan by the fiduciary, and shall be subject to such other equitable or remedial relief as the court may deem appropriate, including removal of such fiduciary. A fiduciary may also be removed for a violation of section 1111 of this title.

(b) No fiduciary shall be liable with respect to a breach of fiduciary duty under this subchapter if such

breach was committed before he became a fiduciary or after he ceased to be a fiduciary.

§1132 Civil enforcement

(a) Persons empowered to bring a civil action

A civil action may be brought –

(1) by a participant or beneficiary –

(A) for the relief provided for in subsection (c) of this section, or

(B) to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan;

§1144 Other laws

(a) Supersedure; effective date

Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a) of this title and not exempt under section 1003(b) of this title. This section shall take effect on January 1, 1975.